State of Maryland
Department of Health and Mental Hygiene

Nelson J. Sabatini
Chairman

Herbert S. Wong, PhD
Vice-Chairman

Joseph Antos, PhD

Victoria W. Bayless

George H. Bone,
M.D.

John M. Colmers

Jack C. Keane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Katie Wunderlich, Director
Engagement
and Alignment

Vacant, Director
Population Based
Methodologies

Chris L. Peterson, Director
Clinical and Financial
Information

Gerard J. Schmith, Director
Revenue and Regulation
Compliance

539th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
April 12, 2017

EXECUTIVE SESSION
11:00 a.m.
(The Commission will begin in public session at 11:00 a.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

1. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

2. **Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104**

3. **Personnel Matters – Authority General Provisions Article, §3-305 (b) (1)**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on March 8, 2017**
2. **Executive Director's Report**
   a. **Update Discussion**
3. **New Model Monitoring**
4. **Docket Status – Cases Closed**
   2373N – Bowie Emergency Center
5. **Docket Status – Cases Open**
   2371R – MedStar Franklin Square Medical Center
   2371A - Doctors Community Hospital
   2379A – Johns Hopkins Health System
   2380A - University of Maryland Medical Center
   2381A – Johns Hopkins Health System
   2382A – Johns Hopkins Health System
6. **Confidential Data Request**
7. **Final Recommendation on Changes to the Relative Value Units Scale for Imaging**
8. **Draft Recommendation to Update the Readmissions Reduction Incentive Program for RY 2019**
9. **Draft Recommendation for Continued Support for the Maryland Patient Safety Center**

10. **Summary of Global Budget Infrastructure Reports**

11. **Disclosure of the Hospital Financial and Statistical Data for Fiscal Year 2016**

12. **Legislative Update**

13. **CRISP Update**

14. **Hearing and Meeting Schedule**

Executive Director’s Report

The Executive Director’s Report will be distributed during the Commission Meeting

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF MARCH 30, 2017

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2371R	MedStar Franklin Square Medical Center	12/23/2016	4/12/2017	5/22/2017	Capital	GS	OPEN
2372A	Doctors Community Hospital	1/5/2017	N/A	N/A	ARM	DK	OPEN
2379A	Johns Hopkins Health System	2/28/2017	N/A	N/A	ARM	DNP	OPEN
2380A	Univerity of Maryland Medical Center	3/24/2017	N/A	N/A	ARM	DNP	OPEN
2381A	Johns Hopkins Health System	3/30/2017	N/A	N/A	ARM	DNP	OPEN
2382A	Johns Hopkins Health System	3/30/2017	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2017**
SYSTEM	*	**FOLIO:**	**2189**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2379A**

Staff Recommendation

April 12, 2017

I. INTRODUCTION

On February 28, 2017, the Johns Hopkins Health System ("System") filed an application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to participate in a global rate arrangement for Kidney Transplant, Pancreas Transplant, Joint Replacement, Blood and Bone Marrow Transplant, and cardiovascular services with Coventry Health Care of Delaware, Inc. The Hospitals request that the Commission approve the arrangement for one year effective April 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payment, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Since the System has achieved favorable experience in developing global prices in other arrangements for the services to be provided under this arrangement, staff believes that the Hospitals can achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Kidney Transplant, Pancreas Transplant, Joint Replacement, Blood and Bone Marrow Transplant, and cardiovascular services for one year beginning April 1, 2017. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2017**
MEDICAL CENTER	*	**FOLIO:**	**2190**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2380A**

Staff Recommendation

April 12, 2017

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on March 24, 2017 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver, kidney, lung, and blood and bone marrow transplants for a period of one year with Cigna Health Corporation beginning June 1, 2017.

II. OVE RVIEW OF APPLICATION

The contract will continue be held and administered by University Physicians, Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. ST AFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver, kidney, lung, and blood and bone marrow transplant services, for a one year period commencing June 1, 2017. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2017**
SYSTEM	*	**FOLIO:**	**2191**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2281A**

Staff Recommendation

April 12, 2017

I. INTRODUCTION

On March 30, 2017, Johns Hopkins Health System ("System") filed an alternative rate application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") the application requests approval from the HSCRC to continue to participate in a global rate arrangement with Global Medical Management, Inc., formally known as the Corporate Medical Network, for cardiovascular procedures, solid organ, stem cell, and to add bariatric surgery, pancreatic cancer surgery, and joint replacement services to the arrangement. The Hospitals request that the Commission approve the arrangement for one year beginning May 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the

Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff finds that the actual experience under the arrangement for the last year has been slightly unfavorable. The global prices for the cases associated with the loss have been updated and, therefore, staff believes that the Hospitals can achieve a favorable experience under the revised arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures, solid organ transplants, stem cell transplant, bariatric surgery, pancreatic cancer surgery, and joint replacement services for one year beginning May 1, 2017. The Hospitals must file a renewal application annually for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION *		COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2017
SYSTEM	*	FOLIO:	2192
BALTIMORE, MARYLAND	*	PROCEEDING:	2382A

Staff Recommendation

April 12, 2017

I. INTRODUCTION

On March 30, 2017, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning May 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the System hospitals and to bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates, which was originally developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid, has been adjusted to reflect recent hospital rate increases. The remainder of the global rate is comprised of physician service costs. Additional per diem payments, calculated for cases that exceeded a specific length of stay outlier threshold, were similarly adjusted.

IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC

maintains that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

The staff found that the experience under the arrangement has been favorable for the last year. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for the period beginning May 1, 2017. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Staff Recommendation on the Johns Hopkins Health System Request to Access HSCRC Confidential Patient Level Data.

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

April 12, 2017

This is a final recommendation for Commission consideration at the April 12, 2017 Public Commission Meeting.

SUMMARY STATEMENT

The Johns Hopkins Health System (JHHS) is requesting access to a limited confidential dataset to construct a diagnostic dashboard for internal quality assessment and improvement (QA/QI).

OBJECTIVE

To accomplish this research, JHHS will be using limited variables from the confidential inpatient and outpatient datasets to develop a QA/QI dashboard to reduce diagnostic errors in ambulatory care settings, particularly in the emergency department (ED) and primary care (PC). The limited dataset will include confidential variables such as the JHHS patient medical record number, dates of service, as well as location for patients seen at any JHHS regulated-space entity. JHHS will provide International Classification of Diseases (ICD) codes to CRISP, and CRISP will identify all JHHS patients in the case mix data that meet the criteria. Investigators received approval from Johns Hopkins Medicine, Office of Human Subjects Research Institutional Review Board (IRB) on February 27, 2017. These data will not be used to identify individual hospitals or patients. The data will be retained by JHHS until January 24, 2022; at that time, the files will be destroyed and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for Confidential Data are reviewed by the Health Services Cost Review Commission Confidential Data Review Committee. The role of the Review Committee is to review applications and make recommendations to the Commission at its monthly public meeting. Applicants requesting access to the confidential data must demonstrate:

1. that the proposed study/ research is in the public interest;
2. that the study/ research design is sound from a technical perspective;
3. that the organization is credible;
4. that the organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations;
5. that there are adequate data security procedures to ensure protection of patient confidentiality.

The independent Confidential Data Review Committee (comprised of representatives from HSCRC staff, the Department of Health and Mental Hygiene ("DHMH"), and the Hilltop Institute at the University of Maryland Baltimore County) reviewed the application to ensure it met the above minimum requirements as outlined in the application form.

The Confidential Review Committee unanimously agreed to recommend access to a confidential limited data set. As a final step in the evaluation process, the applicant will be required to file annual progress reports to the Commission, detailing any changes in goals or design of project, any changes in data handling procedures, work progress, and unanticipated events related to the confidentiality of the data. Additionally, the requester will submit to HSCRC a copy of the final report for review prior to public release.

STAFF RECOMMENDATIONS

1. HSCRC staff recommends that the request for the limited inpatient and outpatient confidential data files for Calendar Year 2011 through 2015 be approved.

2. This access will be limited to identifiable data for JHHS patients meeting certain criteria.

Final Staff Recommendation
Changes to Relative Value Units for Imaging Services

April 12, 2017

The Commission staff recommends that the Commission approve revisions to the Relative Value Unit (RVU) Scale for Radiology- Diagnostic (RAD), Nuclear Medicine (NUC), CT Scanner (CAT), Magnetic Resonance Imaging (MRI), and Electroencephalography (EEG) services. The revisions are specific to Chart of Accounts and Appendix D of the Accounting and Budget Manual. These revised RVUs were developed by a workgroup established by the Health Services Cost Review Commission. The workgroup's membership included representatives of many Maryland hospitals.

The RVU scale was updated to reflect new additions to the Current Procedural Terminology (CPT) codes; to reflect changes in clinical practices; and to eliminate the reporting of "By Report" to ensure standardized charging practices for RAD, NUC, CAT, MRI and EEG services. The proposed changes were sent to all hospitals for comment. The comment period closed on March 29, 2017 with receipt of several comments. Staff has addressed the comments. The changes resulting from the comments did not significantly alter the revised RVUs. Hospitals will be required to calculate a conversion factor to assure no change in hospital revenue as a result of this revision. Hospitals will begin using these revised RVUs effective July 1, 2017.

Radiology- Diagnostic
Section 200- Chart of Accounts

Final Recommendation 4-12-2017

7320		RADIOLOGY-DIAGNOSTIC
	7322	Ultrasonography
	7339	Radiology-Diagnostic-Other

Function

This cost center provides diagnostic radiology services as required for the examination and care of patients under the direction of a qualified radiologist. Diagnostic radiology services include the patient registration, taking, processing, examining and unofficial interpretation by a non-physician or other qualified medical staff of radiology services defined below, and up to six hours of recovery time. Radiology examinations for this Cost Center include general diagnostic radiology, ultrasound, fluoroscopy and mammography and excludes Computed Tomography, Magnetic Resonance Imaging (MRI and MRA), Radiation Therapy, Nuclear Medicine, and Interventional Radiology/Cardiovascular and Radiology procedures with a surgical component. Additional activities include, but are not limited to, the following:

> Consultation with patients and attending physicians; radioactive waste disposal, storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing diagnostic radiology services. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (including Drugs incident to Radiology, i.e. contrast media) etc. purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the Radiology-Diagnostic cost center.

Reporting Schedule

Schedule D - Line D32

Diagnostic Radiology, Ultrasound and Vascular Ultrasound

Approach

Diagnostic-Radiology Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ~~one hundred~~ ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only (such as treatment codes), the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPT 70170, 74190, 74235, 74300, 74301, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74450, 74470, 74485, 74740, 74742, 75801, 75803, 75805, 75807, 75810, 75894, 75952, 75954, 75956, 75957, 75958, 75959, 75970, 76930, 76932, 76940, 76941, 76945 and 76975 did not have a published RVU in the MPFS. As these codes are bundled with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    b. CPT 74420 did not have a published RVU in the MPFS. The work group agreed the work activity associate with this code is similar to CPT 74415. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 74420.
    c. CPT 74445 did not have a published RVU in the MPFS. The work group agreed that this code is priced similar to CPT 74415 by various state Medicaid agencies. Given the similarity in pricing it was determined the same RVU should be applied to CPT 74445.
    d. CPT 74775 did not have a published RVU in the MPFS. The group agreed that this code is priced similar to CPT 74455 by various state Medicaid agencies. Given the similarity in pricing it was determined the same RVU should be applied to CPT 74775. Note: 74455 is moving to RIC but its federal RVU was used for 74775.

e. CPT 76001 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 76000. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 76001.
f. CPT 76125 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 76120. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 76125.
g. CPT 76140 did not have a published RVU in the MPFS. This code is a professional fee and weighted at 0.
h. CPT 76496, 76499 and 76999 did not have a published RVU in the MPFS. As these codes are for unlisted procedures, the group agreed these codes should be considered "By Report" and RVUs should be developed using the guidelines below.
i. CPT 76998 does not have a published RVU in the MPFS. As this service is for guidance, the group agreed to mirror fluoroscopic guidance CPT 76000 (11 RVUs).
j. CPT 77061 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 77063. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77061.
k. CPT 77062 did have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 77063. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77062.
l. CPT 77065 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 26 RVUs to mirror HCPCS code G0206.
m. CPT 77066 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 34 RVUs to mirror HCPCS code G0204.
n. CPT 77067 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 28 RVUs to mirror HCPCS code G0202.
o. CPT 93315, 93317 and 93318 did not have a published RVU in the MPFS. The group agreed that these codes should be reported under the Electrocardiology section of Appendix D.
p. CPT 93895 did not have a published RVU in the MPFS. This service is non-covered by Medicare and should be developed "By Report" following the protocol listed below.
q. CPT 93998 did not have a published RVU in the MPFS. As this code are for unlisted procedures, the group agreed these codes should be considered "By Report" and RVUs should be established using the guidelines below.
r. HCPCS code C9744 did not have a published RVU in the MPFS. This code is similar to CPT 76705, however, testing time is approximately double. A factor of 1.88 to account for additional testing time will be applied to the RVU value for CPT 76705 and will be assigned 34 RVUs (1.88 x 18= 33.84).
s. HCPCS R0070 and R0075 did not have a published RVU in the MPFS. The group agreed that these codes were not diagnostic and therefore were excluded from Appendix D.

3. CPT/HCPCS codes for which the published RVU did not make sense,
   a. G0365 is a level II HCPCS associated with other vessel mapping services. To allow flexibility for reporting this service to all payers, it will be listed as "By Report."

Services With Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. When a Radiology CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center.

Labor & Delivery Imaging

CPT codes that are listed in both Radiology and Labor & Delivery (e.g. Obstetrical Ultrasound) are to be charged based on where performed and the personnel performing the procedure. Procedures performed by Radiology staff are to be charged through Radiology and procedures performed by Labor & Delivery staff are to be charged through Labor & Delivery

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the FY 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1XXXX – 6XXXX) and being performed in the imaging suite, these services are not "By Report", they are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

No additional RVUs are to be added to portable procedures regardless when or where the service is performed.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any Radiology- Diagnostic examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

CPT Code	Description	RVU
70010	Myelography, posterior fossa, supervision and interpretation only	IRC
70015	Cisternography, positive contrast, supervision and interpretation only	26
70030	Radiological exam, eye, for detection of foreign body	5
70100	Radiological exam, mandible, partial, less than four views	7
70110	Radiological exam, mandible, complete, minimum four views	7
70120	Radiological exam, Mastoids, less than three views per side	7
70130	Radiological exam, Mastoids complete, minimum of three views per side	10
70134	Radiological exam, Internal auditory meati, complete	10
70140	Radiological exam, Facial bones, less than three views	5
70150	Radiological exam, Facial Bones complete, minimum of three views	8
70160	Radiological exam, Nasal bones, complete, minimum of three views	7
70170	Dacryocystography, Nasolacrimal duct, radiological supervision and interpretation	IRC
70190	Radiological exam, Optic foramina	7
70200	Radiological exam, Orbits, complete, minimum of four views	8
70210	Radiological exam, Sinuses, paranasal, less than three views	6
70220	Radiological exam, Sinuses, paranasal complete, minimum of three views	7
70240	Radiological exam, Sella turcica	6
70250	Radiological exam, Skull, less than four views	7
70260	Radiological exam, Skull complete, minimum of four views	8
70300	Radiological exam, Teeth, single view	2
70310	Radiological exam, Teeth partial examination, less than full mouth	8
70320	Radiological exam, Teeth complete, full mouth	11
70328	Radiological exam, Temporomandibular joint, (TMJ) open and closed mouth, unilateral	6
70330	Radiological exam, Temporomandibular joint, (TMJ) open and closed mouth, bilateral	10
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	IRC
70350	Cephalogram (orthodontic)	3
70355	Orthopantogram (e.g., panoramic x-ray)	3
70360	Radiological exam, Neck, soft tissue	5
70370	Radiological exam, Pharynx or larynx, including fluoroscopy &, or magnification technique	17
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	13
70380	Radiological exam, Salivary gland for calculus	7
70390	Sialography, radiological supervision and interpretation only	IRC
71010	Radiological exam, chest, single view, frontal	4
71015	Radiological exam, chest, stereo, frontal	5
71020	Radiological exam, chest, 2 views, frontal & lateral	5

CPT Code	Description	RVU
71021	Radiological exam, chest, 2 views, frontal & lateral w, apical lordotic procedure	6
71022	Radiological exam, chest, 2 views, frontal & lateral w, oblique projections	7
71023	Radiological exam, chest, 2 views, frontal & lateral, w, fluoroscopy	12
~~71025~~	~~Stereo~~	~~3~~
71030	Radiological exam, chest, complete, minimum of 4 views	7
71034	Radiological exam, chest, complete, minimum of 4 views, w, fluoroscopy	17
71035	Radiological exam, chest, special views, (e.g. lateral, decubitus, Bucky studies)	7
71100	Radiological exam, Ribs, unilateral, 2 views	6
71101	Radiological exam, Ribs, unilateral, including posteroanterior chest, minimum of 3 views	6
71110	Radiological exam, Ribs, bilateral, 3 views	7
71111	Radiological exam, Ribs, bilateral, including posteroanterior chest, minimum of 4 views	9
71120	Radiological exam, Sternum, minimum of 2 views	5
71130	Sternoclavicular joint or joints, minimum of 3 views	7
72020	Radiological exam, spine, single view, specify level	4
72040	Radiological exam, spine, cervical, 2 or 3 views	6
72050	Radiological exam, spine, cervical, 4 or 5 views	8
72052	Radiological exam, spine, cervical, 6 or more views	11
72070	Radiological exam, spine, thoracic, 2 views	6
72072	Radiological exam, spine, thoracic, 3 views	7
72074	Radiological exam, spine, thoracic, minimum 4 views	8
72080	Radiological exam, spine, thoracolumbar junction, minimum 2 views (to report thoracolumbar junction one view see CPT 72020)	5
72081	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); one view	7
72082	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); 2 or 3 views	13
72083	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); 4 or 5 views	14
72084	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); minimum 6 views	17
72100	Radiological exam, spine, lumbosacral, 2 or 3 view(s)	7
72110	Radiological exam, spine, lumbosacral, minimum 4 views	9
72114	Radiological exam, spine, lumbosacral, complete, including bending views, minimum of 6	13

CPT Code	Description	RVU
72120	Radiological exam, spine, lumbosacral, bending views only, 2 or 3 views	8
72170	Radiological exam, pelvis, 1 or 2 view(s)	6
72190	Radiological exam, pelvis, minimum 3 view(s)	8
72200	Radiological exam, sacroiliac joints, less than three views	5
72202	Radiological exam, sacroiliac joints, 3 or more views	7
72220	Radiological exam, sacrum and coccyx, minimum of two views	5
72240	Myelography, cervical, supervison and interpretation only	IRC
72255	Myelography, thoracic, supervision and interpretation only	IRC
72265	Myelography, lumbosacral, supervision and interpretation only	IRC
72270	Myelography, entire spine canal, supervision and interpretation only	IRC
72275	Epidurography, radiological supervision and interpretation (includes 77003)	IRC
72285	Discography, cervical or thoracic, radiological supervision and interpretation	IRC
72295	Discography, lumbar, radiological supervision and interpretation	IRC
73000	Radiological exam, clavicle, complete	5
73010	Radiological exam, scapula complete	6
73020	Radiological exam, shoulder, one view	4
73030	Radiological exam, shoulder, complete, minimum 2 views	5
73040	Radiological exam, shoulder, arthrography, supervision and interpretation only	IRC
73050	Radiological exam, acromioclavicular joints, bilateral, w, or w, o weighted distraction	7
73060	Radiological exam, humerus, minimum two views	6
73070	Radiological exam, elbow, 2 views	5
73080	Radiological exam, elbow complete, minimum of three views	6
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation	IRC
73090	Radiological exam, forearm, 2 views	5
73092	Radiological exam, forearm, upper extremity, infant, minimum of 2 views	5
73100	Radiological exam, wrist, 2 views	6
73110	Radiological exam, wrist complete, minimum of 3 views	7
73115	Radiological examination, wrist, arthrography, radiological supervision and interpretation	IRC
73120	Radiological exam, hand, minimum of 2 views	5
73130	Radiological exam, hand minimum of 3 views	6
73140	Radiological exam, finger(s), minimum of 2 views	7
73501	Radiological exam, hip, unilateral, w, pelvis when performed; 1 view	6
73502	Radiological exam, hip, unilateral, w, pelvis when performed; 2 to 3 views	8
73503	Radiological exam, hip, unilateral, w, pelvis when performed; minimum 4 views	10

CPT Code	Description	RVU
73521	Radiological exam, hips, bilateral, w, pelvis when performed; 2 view	8
73522	Radiological exam, hips, bilateral, w, pelvis when performed; 3 to 4 views	9
73523	Radiological exam, hips, bilateral, w, pelvis when performed; minimum of 5 views	11
73525	Radiologic examiniation, hip, arthrography, radiological supervision and interpretation	IRC
73551	Radiological exam, femur, 1 view	5
73552	Radiological exam, femur, minimum 2 views	6
73560	Radiological exam, knee, 1 or 2 views	6
73562	Radiological exam, knee, 3 views	7
73564	Radiological exam, knee, complete, 4 or more views	8
73565	Radiological exam, both knees, standing , anteroposterior	8
73580	Radiological exam, knee, arthrography, supervision and interpretation only	IRC
73590	Radiological exam, tibia and fibula, 2 views	6
73592	Radiological exam, tibia and fibula, lower extremity, infant, minimum of two views	5
73600	Radiological exam, ankle, 2 views	6
73610	Radiological exam, ankle complete, minimum of 3 views	6
73615	Radiological examination, ankle, arthrography, radiologic supervision and interpretation	IRC
73620	Radiological exam, foot, 2 views	5
73630	Radiological exam, foot, complete, minimum of 3 views	6
73650	Radiological exam, calcaneus, minimum of 2 views	5
73660	Radiological exam, toe(s), minimum of 2 views	6
74000	Radiological exam, abdomen, single anteroposterior view	4
74010	Radiological exam, abdomen, anteroposterior and additional oblique and cone views	7
74020	Radiological exam, abdomen, complete, including decubitus and, or erect views	7
74022	Radiological exam, complete acute abdomen series, including supine, erect, and, or decubitus views, single view chest	8
74190	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation	IRC
74210	Radiological exam, pharynx and, or cervical esophagus	17
74220	Radiological exam, esophagus	18
74230	Swallowing function, with cineradiography, videoradiography	28
74235	Removal of foreign body(s), esophageal, with use of balloon catheter, radiologic supervision and interpretation	IRC
74240	Radiological exam, gastrointestinal tract, upper, w, or w, o delayed films, without KUB with and without delayed films, with KUB	22
74241	Radiological exam, gastrointestinal tract w, or w, o delayed films, with KUB	23

CPT Code	Description	RVU
74245	Radiological exam, gastrointestinal tract, upper, w, small intestines, includes multiple serial images	35
74246	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon, with or without delayed films, without KUB	26
74247	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon, with or without delayed films, with KUB	30
74249	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon, with or without delayed films, without KUB; w, small intestine follow-through	39
74250	Radiological exam, small intestines, includes multiple serial images	22
74251	Radiological exam, small intestines, includes multiple serial images via enteroclysis tube	108
74260	Duodenography hypotonic	89
74270	Radiological exam, colon, barium enema w, or w, o KUB	32
74280	Radiological exam, colon; air contrast with specific high density barium, w, or w, o glucagon	46
74283	Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (e.g.. meconium ileus)	30
74290	Cholecystography, oral contrast	15
74300	Cholangiography and, or pancreatography; intraoperative, radiological supervision and interpretation	IRC
74301	additional set intraoperative, radiological supervision and interpretation	IRC
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	IRC
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	IRC
74330	Combined endoscropic catheterization of the biliary and pancreatic ductal systems, radiological supervision and intepretation	IRC
74340	Introduction of long gastrointestinal tube (e.g. Miller-Abbott) with multiple fluoroscpies and films	IRC
74355	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation	IRC
74360	Intraluminal dilation of strictures and, or obstructions (eg esophagus) radiological supervision and interpretation	IRC
74363	Percutaneous transhepatic dilation of biliary duct structure w, or w, o placement of stent, radiological supervision & interpretation	IRC
74400	Urography (pyelography), intravenous, w, or w, o KUB, w or w, o tomography	IRC

CPT Code	Description	RVU
74410	Urography, infusion, drip technique and, or bolus technique	24
74415	Urography, infusion, drip technique and, or bolus technique, with nephrotomography	31
74420	Urography, retrograde, w, or w, o KUB	31
74425	Urography, antegrade (pyleostogram, nephrostogram, loopogram) supervision and intepretation only	IRC
74430	Cystography, contrast or chain, minimum of 3 views, supervision and interpretation only	IRC
74440	Vasography, vesiculography, epididymography, radiological supervision and interpretation only	IRC
74445	Corpora cavernosography, radiological supervision and interpretation	31
74450	Urethrocystography, retrograde, radiological supervision and interpretation only	IRC
74455	Urethrocystography, voiding, radiological supervision and interpretation only	IRC
74470	Radiological exam, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation only	IRC
74485	Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation	IRC
74710	Pelvimetry, with or without placental localization	5
74740	Hysterosalpingogram, supervision and intepretation only	IRC
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	IRC
74775	Perineogram (e.g.. vaginogram, for sex determination or extent of anomalies)	18
75600	Aortography, thoracic, without serialography, radiological supervision and interpretation	IRC
75605	Aortography, thoracic, by serialography, radiological supervision and interpretation	IRC
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	IRC
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	IRC
75658	Angiography, brachial, retrograde, radiological supervision and interpretation	IRC
75705	Angiography, spinal, selective, radiological supervision and interpretation	IRC
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	IRC
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	IRC
75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	IRC

CPT Code	Description	RVU
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	IRC
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	IRC
75736	Angiography, pelvic, selective or supraselective, radiological supervision and interpretation	IRC
75741	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation	IRC
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	IRC
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	IRC
75756	Angiography, internal mammary, radiological supervision and interpretation	IRC
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	IRC
75801	Lymphangiography, extremity only, unilateral, radiological supervision and interpretation	IRC
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	IRC
75805	Lymphangiography, pelvic, abdominal, unilateral, radiological supervision and interpretation	IRC
75807	Lymphangiography, pelvic, abdominal, bilateral, radiological supervision and interpretation	IRC
75809	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation	IRC
75810	Splenoportography, radiological supervision and interpretation	IRC
75820	Venography, extremity, unilateral, radiological supervision and interpretation	IRC
75822	Venography, extremity, bilateral, radiological supervision and interpretation	IRC
75825	Venography, caval, inferior, with serialography, radiological supervision and interpretation	IRC
75827	Venography, caval, superior, with serialography, radiological supervision and interpretation	IRC
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation	IRC
75833	Venography, renal, bilateral, selective, radiological supervision and interpretation	IRC
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	IRC
75842	Venography, adrenal, bilateral, selective, radiological supervision and interpretation	IRC

CPT Code	Description	RVU
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	IRC
75870	Venography, superior sagittal sinus, radiological supervision and interpretation	IRC
75872	Venography, epidural, radiological supervision and interpretation	IRC
75880	Venography, orbital, radiological supervision and interpretation	IRC
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	IRC
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	IRC
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation	IRC
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation	IRC
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation	IRC
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	IRC
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	IRC
75901	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation	IRC
75902	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation	IRC
75952	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation	IRC
75953	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery, aneurysm, pseudoaneurysm, dissection, radiological supervision and interpretation	IRC
75954	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation	IRC
75956	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	IRC

CPT Code	Description	RVU
75957	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	IRC
75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	IRC
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	IRC
75970	Transcatheter biopsy, radiological supervision and interpretation	IRC
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation	IRC
75989	Radiological guidance (fluro, US or CT) for percutaneous drainage (e.g. abscess, specimen collection) w, placement of catheter, radiological supervision and interpretation	IRC
76000	Fluoroscopy (separate procedure- other than 71034 or 71023) up to 1 hour physician or other qualified health care professional time (e.g. cardiac fluoroscopy)	11
76001	Fluoroscopy, more than 1 hour physician or other qualified health care professional time, assisting a non-radiological physician or other qualified health care professional (e.g. Nephrosto-lithotomy, ERCP, bronchoscopy, transbronchial biopsy)	11
76010	Radiologic exam from nose to rectum for foreign body, single view, child	5
76080	Radiological exam, abscess, fistula or sinus tract study, radiological supervision and interpretation	8
76098	Radiological exam, surgical specimen	2
76100	Radiologic exam, single plane, body section (eg. tomography) other than w, urography	17
76101	Radiological examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	27
76102	Radiological examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral	39
76120	Cineradiography, videography, except where specifically included	18
76125	Cineradiography, videography to complement routine examination	18
76140	Consultation on x-ray examination made elsewhere, written report	0

CPT Code	Description	RVU
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; **not** requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; **requiring** image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	By Report
76499	Unlisted diagnostic radiographic procedure (see guidelines)	By Report
76506	Echoencephalography, real time w, image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities) including A-mode encephalography as secondary component where indicated	24
76510	Opthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	23
76511	Opthalmic ultrasound, diagnostic; quantitative A-scan only, performed during the same patient encounter	14
76512	Opthalmic ultrasound, diagnostic; B-scan (w, or w, o superimposed non-quantitative A-scan) performed during the same patient encounter	11
76513	Opthalmic anterior segment ultrasound, diagnostic; immersion (water bath) B-scan or high resolution biomicroscopy performed during the same patient encounter	17
76514	Opthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) performed during the same patient encounter	1
76516	Opthalmic biometry by ultrasound, echography, A-scan	13
76519	Opthalmic biometry by ultrasound, echography, A-scan w, intraocular lens power calculation	15
76529	Ophthalmic ultrasonic foreign body localization	13
76536	Ultrasound soft tissue of head and neck (thyroid, parathyroid, parotid), real-time w, image documentation	25
76604	Ultrasound chest (includes mediastinum) real-time w, image documentation	17
76641	Ultrasound breast, unilateral, real-time w, image documentation includes axilla when performed; complete	20
76642	Ultrasound breast, unilateral, real-time w, image documentation includes axilla when performed; limited	15
76700	Ultrasound, abdominal, real time w, image documentation; complete	23

CPT Code	Description	RVU
76705	Ultrasound, abdominal, real time w, image documentation; limited (ie single organ, qudrant, follow-up)	18
76706	Ultrasound, abdominal aorta, real time w/ image documentation, screening study for abdominal aortic aneurysm (AAA)	19
76770	Ultrasound, retroperitoneal (eg renal, aorta, nodes), real time w, image documentation; complete	22
76775	Ultrasound, retroperitoneal (eg renal, aorta, nodes), real time w, image documentation; limited	8
76776	Ultrasound, transplanted kidney, real time & duplex doppler w, image documentation;	34
76800	Ultrasound, spinal canal and contents	23
76801	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, first trimester (<14 wks 0 days) transabdominal approach; single or first gestation	21
76802	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, first trimester (<14 wks 0 days) transabdominal approach; each additional gestation	6
76805	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, after first trimester (> or = 14 wks 0 days) transabdominal approach; single or first gestation	26
76810	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic examination, transabdominal approach; each addt'l gestation	12
76811	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic exam, transabdominal approach; single or first gestation	24
76812	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic exam, transabdominal approach; each additional gestation	32
76813	Ultrasound, pregnant uterus, real-time w, image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	17
76814	Ultrasound, pregnant uterus, real-time w, image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation	8
76815	Ultrasound, pregnant uterus, real-time w, image documentation, limited (eg fetal heart beat, placental location, fetal position and, or qualitative amniotic fluid volume), 1 or more fetus	15
76816	Ultrasound, pregnant uterus, real-time w, image documentation, follow-up (eg re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach , per fetus	20
76817	Ultrasound, pregnant uterus, real-time w, image documentation; transvaginal	17
76818	Fetal biophysical profile; w, non-stress testing	20

CPT Code	Description	RVU
76819	Fetal biophysical profile; w, o non-stress testing	14
76820	Doppler velocimetry, fetal; umbilical artery	6
76821	Doppler velocimetry, fetal; middle cerebral artery	16
76825	Echocardiography, fetal, cardiovascular system, real-time w, image documentation (2D); w, or w, o M-mode recording	55
76826	Echocardiography, fetal, cardiovascular system, real-time w, image documentation (2D); w, or w, o M-mode recording; follow-up or repeat study	35
76827	Doppler Echocardiography, fetal pulsed wave and, or continous wave w, spectral display; complete	13
76828	Doppler Echocardiography, fetal pulsed wave and, or continous wave w, spectral display; follow-up or repeat study	7
76830	Ultrasound, transvaginal	25
76831	Endovaginal introduction of the saline enhanced endrometrium	IRC
76856	Ultrasound pelvic (non-obstetric) real time w, image documentation; complete	21
76857	Ultrasound pelvic (non-obstetric) real time w, image documentation; limited or follow-up (eg follicles)	7
76870	Ultrasound scrotum and contents	10
76872	Ultrasound, transrectal	17
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning	26
76881	Ultrasound, extremity, non-vascular, real-time w, image documentation; limited; complete	25
76882	Ultrasound, extremity, non-vascular, real-time w, image documentation; anatomic specific	3
76885	Ultrasound, infant hips, real-time w, image documentation; dynamic; (requiring physician or other healthcare prof. manipulation)	31
76886	Ultrasound, infant hips, real-time w, image documentation; limted; static; (NOT requiring physician or other healthcare prof. manipulation)	22
76930	US guided aspiration of pericardium	IRC
76932	US guided endomyocardial biopsy	IRC
76936	US scan to localize and therapeutically compress a pseudo-aneurysm	IRC
76937	US guided for vascular access requiring US eval., of potential access sites, vessel patency, visualization of vascular needle entry w, permanent recording and reporting	IRC
76940	US guidance for & monitoring of parenchymal tissue ablation	IRC
76941	US guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	IRC
76942	US guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), imaging supervision and interpretation	IRC

CPT Code	Description	RVU
76945	US guidance for chorionic villus sampling, imaging supervision and interpretation	IRC
76946	US guidance for amniocentesis, imaging supervsion and interpretation	IRC
76948	US guidance for aspiration of ova, imaging supervision and interpretation	IRC
76965	US guidance for interstitial radioelement application	IRC
76970	Ultrasound study follow-up (specify)	21
76975	Gastrointestinal endoscopic ultrasound, supervision and interpretation	IRC
76977	US bone density measurement and interpretation, peripheral site(s); any method	1
76998	Ultrasonic guidance, intraoperative	11
76999	Unlisted ultrasonic procedure (eg diagnostic)	By Report
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	IRC
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) ** NOTE surgical &, or injection codes listed depends on anatomical location	IRC
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)	IRC
77053	Mammary ductogram or galactogram, single ducts, radiological supervision and interpretation	11
77054	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation	15
77061	Digital breast tomosynthesis; unilateral (add 1 addiotional RVU when reported in conjunction with G0204 or G0206)	7
77062	Digital breast tomosynthesis; bilateral (add 1 additional RVU when reported in conjunction with G0204 or G0206)	7
77063	Screening digital breast tomosynthesis; bilateral (list separately in addition to code for primary procedure)	7
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	26
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	34
77067	Screening mammography, bilateral (2 view study of each breast), including computer-aided detection (CAD) when performed	28

CPT Code	Description	RVU
77071	Manual application of stress performed by physician or other qualified healthcare professional for joint radiography; including contralateral joint if indicated	9
77072	Bone age studies	4
77073	Bone length studies (orthoroentgenogram)	6
77074	Radiologic examination, osseous survey, limited (eg. for metastasis)	12
77075	Radiologic examination, osseous survery; complete (axial and appendicular skeleton)	17
77076	Radiologic examination, osseous survey, infant	17
77077	Joint survey, single view, one or more joints (specify)	6
77080	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; axial skelton (eg hips, pelvis, spine)	9
77081	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; appendicular skeleton (eg hips, pelvis, spine)	5
77085	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; appendicular skeleton (eg hips, pelvis, spine) including vertebral fracture assessment	11
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	7
93880	Duplex scan of extracranial vessels complete bilateral study	46
93882	Duplex scan of extracranial vessels, unilateral or limited study	29
93886	Transcranial doppler study of the intracranial arteries; complete	65
93888	Transcranial doppler study of the intracranial arteries; limited	35
93890	Transcranial doppler study of the intracranial arteries; vasoreactivity study	66
93892	Transcranial doppler study of the intracranial arteries; emboli detection w, o intravenous microbubble injection	76
93893	Transcranial doppler study of the intracranial arteries; emboli detection w, intravenous microbubble injection	81
93895	Quantitative carotid intima media thickness and carotid atheroma eval; bilateral	By Report
93922	Limited bilateral non-invasive physiologic study of Upper or Lower extremities arteries; (eg, for lower extremity: ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries w, transcutaneous oxygen tension measurement at 1-2 levels	21

CPT Code	Description	RVU
93923	Complete bilateral non-invasive physiologic studies of Upper or Lower extremities arteries; 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurement at 3 or more levels, or single level study with provocative functional maneuvers (eg, measurements with postural provocative tets, or measurements with reactive hyperemia)	32
93924	Non-Invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing (i.e. bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle, brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study	41
93925	Duplex scan of lower extremity arteries or arterial bypass grafts, complete bilateral study	62
93926	Duplex scan of lower extremity arteries or arterial bypass grafts, unilateral or limited study	36
93930	Duplex scan of upper extremity arteries or arterial bypass grafts, complete bilateral study	47
93931	Duplex scan of upper extremity arteries or arterial bypass grafts, unilateral or limited study	29
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	46
93971	Duplex scan of lower extremity veins including responses to compression and other maneuvers, unilateral or limited study	28
93975	Duplex scan of arterial inflow or venous outflow of abdominal, Pelvic and, or scrotal contents and, or retroperitoneal organs; complete study	63
93975	Duplex scan of arterial inflow or abdominal, pelvic and, or retroperitoneal organs, complete study	63
93976	Duplex scan of arterial inflow or venous outflow of abdominal, Pelvic and, or scrotal contents and, or retroperitoneal organs; limited study	35
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature or bypass grafts, complete study	43
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature or bypass grafts, unilateral or limited study	27

CPT Code	Description	RVU
93980	Duplex scan of arterial inflow and venous outflow of penile vessels, complete study	17
93981	Duplex scan of arterial inflow and venous outflow of penile vessels, follow-up or limited study	15
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording analysis of perssure and waveform tracings, interpretation and report	9
93990	Duplex scan of hemodialysis access including arterial inflow, body of access and venous outflow	38
93998	Unlisted noninvasive vascular diagnostic study	By Report
C9744	Ultrasound, abdominal, with contrast	34
G0365	Vessel mapping of vessels for hemodialysis access	By Report
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema (Medicare reporting only)	46
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema (Medicare reporting only)	46
G0121	Colorectal cancer screening; colonscopy on individual not meeting criteria for high risk (Medicare reporting only)	53.0
G0130	Single energy x-ray absorptiometry (sexa) bone density study, on ore more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Medicare reporting only)	6
G0202	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed (Medicare reporting only)	28
G0204	Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral (Medicare reportiong only)	34
G0206	Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral (Medicare reporting only)	26
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206) (Medicare reporting only)	7

Nuclear Medicine
Section 200- Chart of Accounts

Final Recommendation 4-12-2017

7380	NUCLEAR MEDICINE
7381	NUCLEAR MEDICINE-DIAGNOSTIC
7382	NUCLEAR MEDICINE-THERAPEUTIC

Function

This cost center provides diagnosis and treatment by injectable or ingestible radioactive isotopes as required for the care and treatment of patients under the direction of a qualified physician. Additional activities include, but are not limited to, the following:

> Consultation with patients and attending physician; radioactive waste disposal; storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing nuclear medicine services to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the Nuclear Medicine Cost Center.

Reporting Schedule

Schedule D - Line D35

Nuclear Medicine Appendix D

Final Recommendation 4-12-2017

Approach

Nuclear Medicine Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPTs 78099, 78199, 78299, 78399, 78499, 78599, 78699, 78799 and 78999 did not have a published RVU in the MPFS. As these codes are for an unlisted procedure, RVUs should be developed "By Report" following the protocol below in the section "CPT Codes Without an Assigned RVU Value."
    b. CPT 78267 did not have a published RVU in the MPFS. Due to its similarity to CPT 78270 in time and resources, it was assigned 26 RVUs.
    c. CPT 78268 did not have a published RVU in the MPFS. As time and resources used are about one-half of CPT 78267, it was assigned 13 RVUs.
    d. CPT 78282 did not have a published RVU in the MPFS. CMS APC weights for this code are similar to other gastrointestinal codes that are assigned approximately 2.5 RVUs per the MPFS, it was assigned 25 RVUs.
    e. CPT 78351 did not have a published RVU in the MPFS. Due to its similarity to CPT 78350 in time and resources, it was assigned 6 RVUs.
    f. CPT 78414 did not have a published RVU in the MPFS. Due to its similarity to CPT 78320 in assigned CMS APC weights, it was assigned 52 RVUs.
    g. CPTs 0331T and 0332T are new technology CPTs and did not have published RVUs in the MPFS. 0331T will mirror 78453 (74 RVUs) as workload is comparable and 0332T will mirror 78452 (115 RVUs) due to comparable workload.

h. CPTs 78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813 78814 78815 and 78816 did not have a published RVU in the MPFS. The workgroup agreed that two (2) RVUs per minute for average testing time plus an additional one (1) RVU per minute to account for machine cost and other resources is a reasonable basis for establishing RVUs for PET scans for a total of 3 RVUs per minute as follow:

CPT CODE	AVERAGE TESTING TIME	RVUS
78459	240 minutes	720
78491	80 minutes	240
78492	150 minutes	450
78608	120 minutes	360
78609	120 minutes	360
78811	90 minutes	270
78812	120 minutes	360
78813	150 minutes	450
78814	120 minutes	360
78815	145 minutes	435
78816	165 minutes	495

3. CPT/HCPCS codes for which the published RVU did not make sense,

   a. CPT 38792 did not have a published non-facility RVU, the facility RVU was used.

Services with both a HCPCS for Medicare and CPT for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. If a NUC CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center. (This is minimal for Nuclear Medicine.)

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be

used. These cases are to be charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1xxxx-6xxxx) and being performed in the imaging suite, these services are not "By Report"; they are to be reported via IRC. There is one exception to this rule – see Sentinel Node information below

Sentinel Node Injection

CPT 38792, although in the surgical series of CPT, will be kept in the NUC rate center with its associated RVUs of 6.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug, including radiopharmaceuticals, is considered a routine part of any NUC examination. Radiopharmaceuticals and sedation and pain reducing agents may be used with these procedures. These drugs should NOT be included in the RVU of the exam and are to be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU

CPT Code	Description	RVU
38792	Injection procedure, radioactive tracer for identification of sentinel node	6
78012	Thyroid uptake, single or multiple quantitative measurements including stimulation, suppression, or discharge, when performed.	21
78013	Thyroid imaging (including vascular flow, when performed)	50
78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurements(s) (including stimulation, suppression, or discharge, when performed)	63
78015	Thyroid carcinoma metastases imaging; limited area (e.g. neck/chest only)	55
78016	Thyroid carcinoma metastases imaging; w/additional studies (e.g., urinary recovery)	73
78018	Thyroid carcinoma metastases imaging; whole body	79
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	16
78070	Parathyroid planar imaging (including subtraction, when performed)	76
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	87
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	98
78075	Adrenal imaging, cortex and/or medulla	119
78099	Unlisted endocrine procedure, diagnostic nuclear medicine	By Report
78102	Bone marrow imaging; limited area	42
78103	Bone marrow imaging; multiple areas	54
78104	Bone marrow imaging; whole body	61
78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	26
78111	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	24
78120	Red cell volume determination (separate procedure); single sampling	24
78121	Red cell volume determination (separate procedure); multiple samplings	26
78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	22
78130	Red cell survival study;	40
78135	Red cell survival study; differential organ/tissue kinetics (e.g., splenic and/or hepatic sequestration)	94
78140	Labeled red cell sequestration, differential organ/tissue (e.g., splenic and/or hepatic)	31
78185	Spleen imaging only, with or without vascular flow	56
78190	Kinetics, study of platelet survival, with or without differential organ/tissue localization	99
78191	Platelet survival study	40
78195	Lymphatics and lymph node imaging	87
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	By Report
78201	Liver imaging; static only	49
78202	Liver imaging; with vascular flow	52
78205	Liver imaging (SPECT);	52
78206	Liver imaging (SPECT); with vascular flow	86
78215	Liver and spleen imaging; static only	50

CPT Code	Description	RVU
78216	Liver and spleen imaging; with vascular flow	29
78226	Hepatobiliary system imaging, including gallbladder when present;	86
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	118
78230	Salivary gland imaging;	44
78231	Salivary gland imaging; with serial images	30
78232	Salivary gland function study	23
78258	Esophageal mobility	55
78261	Gastric mucosa imaging	62
78262	Gastroesophageal reflux study	61
78264	Gastric emptying study (e.g., solid, liquid, or both)	87
78265	Gastric emptying study (e.g., solid, liquid, or both); with small bowel transit	102
78266	Gastric emptying study (e.g., solid, liquid, or both); with small bowel and colon transit, multiple days	123
78267	Urea breath test, C-14 (isotopic); acquisition for analysis	26
78268	Urea breath test, C-14 (isotopic); analysis	13
78270	Vitamin B-12 absorption study (e.g.. Schilling test); without intrinsic factor	26
78271	Vitamin B-12 absorption study (e.g.. Schilling test); with intrinsic factor	23
78272	Vitamin B-12 absorption study combined, with and without intrinsic factor	25
78278	Acute gastrointestinal blood loss imaging	88
78282	Gastrointestinal protein loss	25
78290	Intestine imaging (e.g., ectopic gastric mucosa, Meckel's localization, volvulus)	87
78291	Peritoneal-venous shunt patency test (e.g., LeVeen, Denver shunt)	62
78299	Unlisted gastrointestinal procedure, diagnostic Nuclear Medicine	By Report
78300	Bone and/or joint imaging; limited area	44
78305	Bone and/or joint imaging: multiple areas	56
78306	Bone and/or joint imaging; whole body	61
78315	Bone and/or joint imaging; 3 phase study	87
78320	Bone and/or joint imaging; tomographic (SPECT)	52
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	6
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	6
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	By Report
78414	Determination of central c-v hemodynamics (non-imaging) (e.g., ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations	52
78428	Cardiac shunt detection	42
78445	Non-cardiac vascular flow imaging (i.e., angiography, venography)	46
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification , when performed); single study, at rest or stress (exercise or pharmacologic)	80

CPT Code	Description	RVU
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification , when performed); multiple studies, at rest and/or redistribution and/or rest reinjection	115
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); singe study, at rest or stress (exercise or pharmacologic)	74
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	108
78456	Acute venous thrombosis imaging, peptide	79
78457	Venous thrombosis imaging, venogram; unilateral	40
78458	Venous thrombosis imaging, venogram; bilateral	47
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation	720
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	47
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	45
78469	Myocardial imaging infarct avid, planar; tomographic SPECT with or without quantification	53
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	53
78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	64
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction with or without quantification	37
78483	Cardiac blood pool imaging (planar) first pass technique; multiple studies, at rest or with stress (exercise and/or pharmacologic) wall motion study plus ejection fraction with or without quantification	50
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	240
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest or stress	450
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	49
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (list separately in addition to code for primary procedure)	6
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	By Report
78579	Pulmonary ventilation imaging (e.g., aerosol or gas)	47
78580	Pulmonary perfusion imaging (e.g., particulate)	59
78582	Pulmonary ventilation (e.g., aerosol or gas) and perfusion imaging	82
78597	Quantitative differential pulmonary perfusion, including imaging when performed	49

CPT Code	Description	RVU
78598	Quantitative differential pulmonary perfusion and ventilation (e.g., aerosol or gas), including imaging when performed	77
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	By Report
78600	Brain imaging, less than 4 static views;	48
78601	Brain imaging, less than 4 static views; with vascular flow	55
78605	Brain imaging, minimum 4 static views;	51
78606	Brain imaging, minimum 4 static views; with vascular flow	87
78607	Brain imaging, tomographic (SPECT)	86
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	360
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	360
78610	Brain imaging, vascular flow only	47
78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	89
78635	Cerebrospinal fluid flow, imaging (not including introduction of material;) ventriculography	91
78645	Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation	87
78647	Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)	90
78650	Cerebrospinal fluid leakage detection and localization	88
78660	Radiopharmaceutical dacryocystography	45
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	By Report
78700	Kidney imaging morphology;	44
78701	Kidney imaging morphology; with vascular flow	55
78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	54
78708	Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	34
78709	Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	87
78710	Kidney imaging morphology; tomographic (SPECT)	50
78725	Kidney function study, non-imaging radioisotopic study	26
78730	Urinary bladder residual study (List separately in addition to code for primary procedure)	18
78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)	56
78761	Testicular imaging with vascular flow	52
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	By Report
78800	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area	46
78801	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas	65
78802	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging	82
78803	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)	85
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging	150

Nuclear Medicine

RVU Final Recommendation 4-12-2017

CPT Code	Description	RVU
78805	Radiopharmaceutical localization of inflammatory process; limited area	43
78806	Radiopharmaceutical localization of inflammatory process; whole body	85
78807	Radiopharmaceutical localization of inflammatory process; tomographic (SPECT)	85
78808	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (e.g., parathyroid adenoma)	11
78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)	270
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	360
78813	Positron emission tomography (PET) imaging; whole body	450
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)	360
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	435
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	495
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	By Report
79005	Radiopharmaceutical therapy, by oral administration	14
79101	Radiopharmaceutical therapy, by intravenous administration	14
79200	Radiopharmaceutical therapy, by intracavitary administration	15
79300	Radiopharmaceutical therapy, by interstitial radioactive colloid administration	IRC
79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	23
79440	Radiopharmaceutical therapy, by intra-articular administration	14
79445	Radiopharmaceutical thearpy, by intra-articular particulate administration	IRC
79999	Radiopharmaceutical therapy, unlisted procedure	By Report
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment	74
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment with tomographic SPECT	115

CT Scanner Section 200- Chart of Accounts

Final Recommendation 4-12-2017

7340 CT SCANNER

Function

The CT Scanner uses computerized tomography imaging in order to diagnose abnormalities.

Description

This cost center shall contain the direct expenses incurred in providing CT scans, patient registration and up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, (including Drugs incident to Radiology, i.e. contrast media), purchased services, equipment, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of relative value units shall be the actual count maintained by the CT Scanner cost center.

Reporting Schedule

Schedule D - Line D33

CT Scanner Appendix D

Final Recommendation 4-12-2017

Approach

CT Scanner Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPT 76497 did not have a published RVU in the MPFS. As this code is for an unlisted procedure, RVUs should be developed "By Report" following the protocol below in the section "CPT Codes Without an Assigned RVU Value.".
    b. CPT 77013 did not have a published RVU in the MPFS. As these codes are bundled with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    c. HCPCS 0042T did not have a published RVU in the MPS. Due to its similarity to CPT 70496, it was assigned 72 RVUs (58 RVUs plus 14 RVUs for double time post processing).
    d. HCPCS 0351T-0354T did not have published RVU in the MPS. These are new technology codes and RVUs should be developed "By Report".
3. CPT/HCPCS codes for which the published RVU did not make sense,
    a. Even though the resources are higher for lung cancer screening patients due to registry and other documentation requirements, HCPCS G0297 (low dose lung cancer screening)

has been synchronized with CPT 71250 (Chest CT wo Contrast) as they often share charge codes within hospitals.

Services With Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. If a CT CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center. Note: These IRC procedures may be charged based on actual start/stop times or based on the average case time (based on an annual time study) for the service.

Surgical Component and Non-Invasive Exam on Same Day

If a patient has a service with a surgical component (invasive) and non-invasive exam on same day – for example, an enhanced CT arthrogram and a CT of the joint- the patient will be charged based on IRC rules for the invasive exam and CT RVUs for the non-invasive exam.

Intrathecal Injections

If intrathecal injections are performed, the service should be reported under IRC. If the service does not include intrathecal injections, standard CT RVUs should be reported.

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are to be charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1xxxx-6xxxx) and being performed in the imaging suite, these services are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any CT examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

CPT Code	Description	RVU
70450	CT Head or Brain w/o contrast	21
70460	CT Head or Brain w contrast	30
70470	CT Head or Brain w & w/o contrast	36
70480	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/o contrast	47
70481	CT Orbit, Sella, Posterior Fossa or ourter, middle or inner ear w/ contrast	58
70482	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/ & w/o contrast	64
70486	CT Maxillofacial area w/o contrast	27
70487	CT Maxillofacial area w contrast	31
70488	CT Maxillofacial area w & w/o contrast	40
70490	CT Soft Tissue Neck w/o contrast	36
70491	CT Soft Tissue Neck w/ contrast	47
70492	CT Soft Tissue Neck w/ & w/o contrast	58
70496	CT Angiography, **Head** w/ contrast, including noncontrast images, if performed and image postprocessing	58
70498	CT Angiography, **Neck** w/ contrast, including noncontrast images, if performed and image postprocessing	57
71250	CT Thorax w/o contrast	36
71260	CT Thorax w/ contrast	47
71270	CT Thorax w/ & w/o contrast	58
71275	CT Angiography, chest (noncoronary) w/ contrast; including noncontrast images, if performed & image postprocessing	59
72125	CT Cervical Spine w/o contrast - Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	37
72126	CT Cervical Spine w/ contrast - Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72127	CT Cervical Spine w/ & w/o contrastConstrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	58
72128	CT Thoracic Spine w/o contrast Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	36
72129	CT Thoracic Spine w/ contrast Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47

CPT Code	Description	RVU
72130	CT Thoracic Spine w/ & w/o contrast Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	58
72131	CT Lumbar Spine w/o contrast Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	36
72132	CT Lumbar Spine w/ contrast Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72133	CT Lumbar Spine w/ & w/o contrast Constrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	58
72191	CT Angiography; Pelvis w/ contrast, including noncontrast images, if performed, and image postprocessing	60
72192	CT Pelvis w/o contrast	26
72193	CT Pelvis w contrast	47
72194	CT Pelvis w/ & w/o contrast	56
73200	CT Upper Extremity w/o contrast	36
73201	CT Upper Extremity w/ contrast	46
73202	CT Upper Extremity w/ & w/o contrast	61
73206	CT Angiography, Upper Extremity w/ contrast; including noncontrast images, if performed and image postprocessing	67
73700	CT Lower Extremity w/o contrast	36
73701	CT Lower Extremity w contrast	47
73702	CT Lower Extremity w/ & w/o contrast	60
73706	CT Angiography, Lower Extremity w/ contrast, including noncontrast images, if performed, and image postprocessing	73
74150	CT Abdomen w/o contrast	25
74160	CT Abdomen w contrast	47
74170	CT Abdomen w/ & w/o contrast	54
74174	CT Angiography, Abdomen & Pelvis w/ contrast material, including noncontrast images, if performed and image postprocessing	78
74175	CT Angiography, Abdomen w/ contrast material,, including noncontrast images, if performed and image postprocessing	61
74176	CT Abdomen & Pelvis w/o contrast material	32
74177	CT Abdomen & Pelvis w contrast	62
74178	CT Abdomen & Pelvis w/ & w/o contrast	71
74261	CT colonography diagnostic, including image postprocessing; w/o contrast	103
74262	CT colonography diagnostic, including image postprocessing; w/ contrast including non-contrast images, if performed	118

CPT Code	Description	RVU
74263	CT colonography, screening, including image postprocessing	180
75571	CT Heart w/o contrast; w/ quantitative evaluation of coronary calcium	20
75572	CT Heart w/ contrast material, for evaluation of cardiac structure & morphology (includes 3D imaging postprocessing, assessment of cardiac function and evaluation of venous structures, if performed)	55
75573	CT Heart w/ contrast material, for evaluation of cardiac structure & morphology in the setting of congenital disease (includes 3D imaging postprocessing, assessment of LV cardiac function, RV structure and function & evaluation of venous structures, if performed)	74
75574	CT Angiography, heart, CABG (coronary arteries and bypass graft - when present), with contrast, includes 3D imaging postprocessing (including evaluation of cardiac structure & morphology, assessment of cardiac function & evaluation of venous structures, if performed)	85
75635	CT Angiography, Abdominal aorta and bilateral iliofemoral lower extremity runoff, w/ contrast, including noncontrast images, if performed, and image postprocessing	74
75989	Radiological Guidance (ie. Fluoroscopy, US, or CT), for percutaneous drainage (ie. Abscess, specimen collection), w/ placement of catheter, radiological supervision and interpretation	IRC
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; **not** requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	4
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; **requiring** image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	9
76380	CT limited or localized follow-up study	27
76497	Unlisted CT Procedure (diagnostic or interventional)	By Report
77011	CT Guidance for stereotactic localization (do not report in conjunction w/ 22586, 0195T, 0196T, 0309T)	IRC
77012	CT Guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), radiological supervision and interpretation (do not report in conjunction w/ 10030, 22586, 27906, 32554-32557, 64479-64484,64490-64495, 64633-64636, 0195T, 0196T, 0232T, 0309T)	IRC
77013	CT Guidance for, and monitoring of, parenchmal tissue ablation (do not report in conjunction w/ 20982, 20983, 0340T)	IRC
77014	CT Guidance for placement of radiation therapy fields	21

CPT Code	Description	RVU
77078	CT Bone mineral density study, 1 or more sites, axial skeleton (hips, pelvis, spine)	29
G0297	Low dose CT scan (LDCT) for lung cancer screening (Medicare reporting only)	36
0042T	Cerebral perfusion analysis using CT w/ contrast, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	72
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	By Report
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	By Report
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	By Report
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	By Report

Final Recommendation 4-12-2017

7350 MRI SCANNER

Function

The MRI Scanner uses magnetic resonance in order to diagnose abnormalities.

Description

This cost center shall contain the direct expenses incurred in providing MRI scans, patient registration and up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician) supplies, (including Drugs incident to Radiology, i.e. contrast media), purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of relative value units shall be the actual count maintained by the MRI Scanner cost center.

Reporting Schedule

Schedule D - Line D51

MRI

Approach

Magnetic Resonance Imaging Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed.
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C").
    a. CPT 77022 did not have a published RVU in the MPFS. As these codes are bundled with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    b. CPT 70557, 70558 and 70559 did not have a published RVU in the MPS. Even though these are performed intraoperatively, they will be charged using standard brain MRI RVUs. They will mirror 70551 (44 RVUs), 70552 (65 RVUs), and 70553 (74 RVUs).
    c. CPT 70555 did not have a published RVU in the MPFS. As this code is similar to 70554, it was set to mirror 70554. See #3 below.
    d. CPT 76498 did not have a published RVU in the MPFS. As this code is for an unlisted procedure, RVUs should be developed "By Report".
    e. CPT 0159T did not have a published RVU in the MPFS. As this procedure is always performed in conjunction with a primary procedure, one RVU will be assigned.
    f. HCPCS 0398T did not have a published RVU in the MPFS. Intracranial procedures are typically performed in the operating room. However, this code is for the MRI piece. Hospital data to establish RVUs is limited as this is a new code and very few hospitals

are performing this procedure. Therefore RVUs should be developed "By Report" following the protocol below in the section "CPT Codes Without an Assigned RVU Value."

3. CPT/HCPCS codes for which the published RVU did not make sense

    a. CPT 70554 has a published RVU in the MPFS that is too low for the amount of resources involved. On the professional side, the physician charges this CPT and CPT 96020. Given the significant time and resources involved, the group felt there was a valid reason for deviating from the prescribed methodology. Therefore, an additional 54 RVUs will be added to the MPFS for a total of 150 (96 + 54 = 150).

Services With Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. If a MRI CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center. Note: These IRC procedures may be charged based on actual start/stop times or based on the average case time (based on an annual time study) for the service.

Surgical Component and Non-Invasive Exam on Same Day

If a patient has a service with a surgical component (invasive) and non-invasive exam on same day – for example, an enhanced MR arthrogram and a MRI of the joint- the patient will be charged based on IRC rules for the invasive exam and MRI RVUs for the non-invasive exam.

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging.. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room-clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1xxxx-6xxxx) and being performed in the imaging suite, these services are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any MRI examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

CPT Code	Description	RVU
70336	MRI Temporomandibular joints	70
70540	MRI Orbit, Face, and/or Neck w/o contrast	66
70542	MRI Orbit, Face, and/or Neck w/ contrast	72
70543	MRI Orbit, Face, and/or Neck w/ & w/o contrast	87
70544	MRA Head w/o contrast	93
70545	MRA Head w contrast	92
70546	MRA Head w/ & w/o contrast	143
70547	MRA Neck w/o contrast	94
70548	MRA Neck w contrast	99
70549	MRA Neck w & w/o contrast	144
70551	MRI Brain (including brain stem), w/o contrast	44
70552	MRI Brain (including brain stem), w/ contrast	65
70553	MRI Brain (including brain stem), w/ & w/o contrast	74
70554	MRI Brain, functional MRI; including test selection and adminitration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	150
70555	MRI Brain, functional MRI; including test selection and adminitration of repetitive body part movement and/or visual stimulation, requiring physician or psychologist administration of entire neurofunctional testing	150
70557	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residualt tumor or residual vascular malformationJ); w/o contrast	44
70558	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation); w/ contrast	65
70559	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation), w/ & w/o countrast	74
71550	MRI Chest (e.g. for evaulation of hilar and mediastinal lymphadenopathy); w/o contrast	96
71551	MRI Chest (e.g. for evaulation of hilar and mediastinal lymphadenopathy); w/ contrast	105
71552	MRI Chest (e.g. for evaulation of hilar and mediastinal lymphadenopathy); w/ & w/o contrast	131
71555	MRA Chest (excluding myocardium) w or w/o contrast	87
72141	MRI, C-spine, spinal canal and contents; w/o contrast	42
72142	MRI, C-spine, spinal canal and contents; w/ contrast	66
72146	MRI, T-spine, spinal canal and contents; w/o contrast	42
72147	MRI, T-spine, spinal canal and contents; w/ contrast	66
72148	MRI, L-spine, spinal canal and contents; w/o contrast	42
72149	MRI, L-spine, spinal canal and contents; w/ contrast	65
72156	MRI, C-spine, spinal canal and contents; w/ & w/o contrast	74
72157	MRI, T-spine, spinal canal and contents; w/ & w/o contrast	75
72158	MRI, L-spine, spinal canal and contents; w/ & w/o contrast	74
72159	MRA spinal canal and contents w **or** w/o contrast	92

RVU Final Recommendation 4-12-2017

CPT Code	Description	RVU
72195	MRI Pelvis w/o contrast	85
72196	MRI Pelvis w/ contrast	91
72197	MRI Pelvis w/ & w/o contrast	110
72198	MRA Pelvis w/ **or** w/o contrast	88
73218	MRI Upper Extremity, other than joint; w/o contrast	84
73219	MRI Upper Extremity, other than joint; w/ contrast	90
73220	MRI Upper Extremity, other than joint; w/ & w/o contrast	110
73221	MRI any Joint of Upper Extremity w/o contrast	47
73222	MRI any Joint of Upper Extremity w/ contrast	83
73223	MRI any Joint of Upper Extremity w/ & w/o contrast	102
73225	MRA Upper Extremity w **or** w/o contrast	91
73718	MRI Lower Extremity, other than joint, w/o contrast	83
73719	MRI Lower Extremity, other than joint, w/ contrast	91
73720	MRI Lower Extremity, other than joint, w/ & w/o contrast	111
73721	MRI any Joint of Lower Extremity w/o contrast	47
73722	MRI any Joint of Lower Extremity w/ contrast	84
73723	MRI any Joint of Lower Extremity w/ & w/o contrast	102
73725	MRA Lower Extremity w/ **or** w/o contrast	87
74181	MRI Abdomen w/o contrast	73
74182	MRI Abdomen w/ contrast	103
74183	MRI Abdomen w & w/o contrast	111
74185	MRA Abdomen, w/ **or** w/o contrast	88
74712	MRI Fetal; including placental and maternal pelvic imaging when performed; single or first gestation	93
74713	MRI Fetal; including placental and maternal pelvic imaging when performed; each additional gestation	39
75557	Cardiac MRI for morphology and function w/o contrast	57
75559	Cardiac MRI for morphology and function w/o contrast; w/ stress imaging	83
75561	Cardiac MRI for morphology and function w/ & w/o contrast	83
75563	Cardiac MRI for morphology and function w/ & w/o contrast; w/ stress imaging	101
75565	Cardiac MRI for velocity flow mapping (list separately in addition to code for primary procedure)	12
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; **not** requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; **requiring** image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76390	Magnetic Resonance Spectroscopy	106

RVU Final Recommendation 4-12-2017

CPT Code	Description	RVU
76498	Unlisted magnetic resonance procedure (e.g. diagnostic, interventional)	By Report
77021	Magnetic Resonance Guidance for needle placement (eg. Biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation (do not report in conjunction w/ 10030,19085, 19287, 32554 ,32555, 32556, 32557 or 0232T)	IRC
77022	Magnetic Resonance Guidance for monitoring of parenchymal tissue ablation	IRC
77058	MRI Breast w/ and/or w/o constrast; unilateral	129
77059	MRI Breast w/ and/or w/o constrast; bilateral	128
77084	MRI Bone Marrow blood supply	87
+0159T	Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, w/ further physician review for interperetation, breast MRI (List separately in addtion to code for primary procedure)	1
0398T	MRI guided high intensity focused US (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic nagivation and frame placement when performed	By Report

7460 ELECTROENCEPHALOGRAPHY

Function

This cost center provides diagnostic electroencephalography services. Specialized equipment is used to record electromotive variations in brain waves and to record electrical potential variation for diagnosis of muscular and nervous disorders. Additional activities include, but are not limited to, the following:

> Wheeling portable equipment to patient's bedside; explaining test procedures to patient; operating specialized equipment; attaching and removing electrodes from patients.

Description

This cost center contains the direct expenses incurred in providing diagnostic electroencephalography services to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, and other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Values as determined by the Health Services Cost Review Commission (See Appendix D of this manual.)

Data Source

The number of Relative Value Units shall be the actual count maintained by the Electroencephalography cost center.

Reporting Schedule

Schedule D - Line D38

Electroencephalography (EEG) Appendix D

Final Recommendation 4-12-2017

Approach

Electroencephalography Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPT 95824 did not have a published RVU in the MPFS. This CPT is infrequently reported by hospitals and will be listed "By Report."
    b. CPT 95941 did not have a published RVU in the MPFS. This procedure is not reportable to Medicare but may be utilized for other payers. This CPT (1 hour of time) will be reported at 3 RVUs, mirroring 94940 (which is for 15 minutes) because physician is not 1:1 with patient.
    c. CPT 95943, 95965, 95966 and 95967 did not have a published RVU in the MPFS. These CPTs will be assigned "By Report" as this procedure is not currently being provided by hospitals. When hospitals do provide this service, RVUs shall be assigned following the protocol below in the section "CPT Codes Without an Assigned RVU Value."
    d. CPT 95951 did not have a published RVU in the MPFS. This CPT is infrequently reported by hospitals and will be listed "By Report."
    e. HCPCS codes G0398, G0399 and G0400 did not have published RVUs as they are for hospital use only. These procedures will mirror CPT 95806 at 30 RVUs.

3. CPT/HCPCS codes for which the published RVU did not make sense,
    a. There were no deviations from published RVUs when present.

Services with both a HCPCS for Medicare and CPT for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

Unattended and Home Sleep Studies

The RVUs for these services assumes the patients are coming to the hospital before and/or after the procedure to be hooked up/educated on equipment and unhooked/discharged from equipment. These RVUs do not relate to the portion of the service occurring without staff and/or at the patient's home.

CPT Codes Without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report." When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVUs will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any EEG examination, however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

Electroencephalography (EEG)

RVU Final Recommendation 4-12-2017

CPT Code	Description	RVU
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	251
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	285
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time	36
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)	12
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	27
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	103
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)	30
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	113
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	155
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	140
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	148
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	75
95813	Electroencephalogram (EEG) extended monitoring; greater than 1 hour	90
95816	Electroencephalogram (EEG); including recording awake and drowsy	85
95819	Electro-encephalogram (EEG); including recording awake and asleep	101
~~95821~~	~~portable, to an alternate facility~~	~~30~~
95822	Electroencephalogram (EEG); recording in coma or sleep only	89
~~95823~~	~~physical or pharmacological, activation~~	~~30~~
95824	Electroencephalogram (EEG); cerebral death evaluation only	By Report
95827	Electroencephalogram (EEG); all night recording	170
95829	Electrocorticogram at surgery (separate procedure)	445
95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording	62
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	9
95832	Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side	9
95833	Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands	11
95834	Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands	15
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	5

CPT Code	Description	RVU
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side	4
95857	Cholinesterase inhibitor challenge test for myasthenia gravis	15
95860	Needle electromyography; 1 extremity with or without related paraspinal areas	20
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	26
95863	Needle electromyography; 3 extremities with or without related paraspinal areas	33
95864	Needle electromyography; 4 extremities with or without related paraspinal areas	39
95865	Needle electromyography; larynx	17
95866	Needle electromyography; hemidiaphragm	19
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	15
95868	Needle electromyography; cranial nerve supplied muscles, bilateral	20
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	20
95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	20
95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied	12
95873	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	15
95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	15
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	16
95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	11
95886	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)	13
95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)	12
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report;	19
95907	Nerve conduction studies; 1-2 studies	12
95908	Nerve conduction studies; 3-4 studies	16
95909	Nerve conduction studies; 5-6 studies	19
95910	Nerve conduction studies; 7-8 studies	25
95911	Nerve conduction studies; 9-10 studies	28
95912	Nerve conduction studies; 11-12 studies	28
95913	Nerve conduction studies; 13 or more studies	31

CPT Code	Description	RVU
95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	11
95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt	14
95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	27
95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	18
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	31
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	30
95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head	31
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	37
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	39
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	31
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	13
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method (for ultrasonography, see 76500 et seq.)	13
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	83
95939	Central motor evoked potential study (transcranial motor stimulation); upper and lower limbs	108
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	3
95941	Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	3
95943	Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change	By Report
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (e.g., 8 channel EEG) recording and interpretation, each 24 hours	71

CPT Code	Description	RVU
95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for pre-surgical localization), each 24 hours	By Report
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended	73
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (e.g., thiopental activation test)	92
95955	Electroencephalogram (EEG) during nonintracranial surgery (e.g., carotid surgery)	45
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse	404
95957	Digital analysis of electroencephalogram (EEG) (e.g., for epileptic spike analysis)	56
95958	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring	99
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	40
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	25
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)	By Report
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)	By Report
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	By Report
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	19
95971	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	14

CPT Code	Description	RVU
95972	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	17
95974	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour	59
+ 95975	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	32
95978	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programing; first hour	71
95979	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programing; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	31
95980	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	4
95981	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	9
95982	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	15
95999	Unlisted neurological or neuromuscular diagnostic procedure	By Report
G0398	Home sleep test/type 2 portable (Medicare reporting only)	30
G0399	Home sleep test/type 3 portable (Medicare reporting only)	30
G0400	Home sleep test/type 4 portable (Medicare reporting only)	30

CPT Code	Description	RVU
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	3

Interventional Radiology/Cardiovascular
Section 200- Chart of Accounts

Final Recommendation 4-12-2017

7310 INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR

Function

The Interventional Radiology/Cardiovascular Department provides special diagnostic, therapeutic, and interventional procedures that include the use of imaging techniques to guide catheters and other devices through blood vessels and other pathways of the body.

Description

This cost center shall contain the direct expenses incurred in providing the above function as well as patient registration and up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), purchased services, maintenance cost (maintenance contracts or bio-medical engineering costs if don in-house) on principal equipment, other direct expenses and transfers. (Disposable D26, Medical Supplies Sold). Cost of contrast material is included in the minute value and should not be assigned separately.

Standard Unit of Measure

IRC minutes are the difference between starting time and ending time plus one minute for each technical Imaging service performed as defined by American Medical Association's (AMA) Current Procedural Terminology (CPT) (i.e. add and additional minute to the start and stop time for each radiology CPT. Start and ending times are defined as follows: Starting time is the beginning of the procedure if general anesthesia is on administered; or the beginning of general anesthesia or conscious sedation administered in the procedure room. Ending time is the removal of the needle or catheter if general anesthesia is not administered; or the end of general anesthesia. In instances where general anesthesia is administered the time the anesthesiologist spends with the patient following the end of the procedure is not to be counted. Sheath removal and hemostasis is considered part of recovery and is not to be counted. Average procedural times are permitted as long as they are validated annually.

Data Source

The number of IRC minutes shall be the actual count maintained by the Interventional Radiology/Cardiovascular Department.

Reporting Schedule

Schedule D - Line D31

Account Number 7310

INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR

Definition of IRC

The Interventional Cardiovascular Services (IVC) rate center is re-named Interventional Radiology/Cardiovascular to better reflect both interventional radiologic and interventional cardiovascular services. The Interventional Radiology/Cardiovascular Department provides special diagnostic, therapeutic, and interventional procedures that include the use of imaging techniques to guide catheters and other devices through blood vessels and other pathways of the body. When these procedures are performed in the operating room and charged with operating room minutes, hospitals may not charge IRC minutes in addition to operating room minutes. All Medical/Surgical supplies utilized in these cases will be billed for separately through the MedSurg Supplies (MSS) rate center.

Assigning RVUs

RVUs are assigned based either on the actual clock minutes it takes to perform the procedure—similar to the assignment of Operating Room minutes or the average minutes it takes to perform the procedure based on an annual time study. Procedures with a separately billable imaging component are assigned a single RVU for the imaging component. It is assumed that the costs associated with the imaging component are already included in the IRC rate center and therefore should not generate additional revenue. A single RVU is reported for the imaging component so that, when appropriate, an imaging CPT code can be included in the coding of the case. In practice, this means hospitals may want to assign in their charge description master a value of one, representing one RVU, to each imaging component associated with an interventional procedure.

Start and Stop Times

The definition of start and stop time for procedures performed in IRC mirrors the definition used in the operating room.

Starting time is:

- The beginning of the procedure if general anesthesia is not administered, or
- The beginning of general anesthesia or conscious sedation administered in the procedure room

Ending time is:

- Removal of the needle or catheter, if general anesthesia is not administered, or
- The end of general anesthesia.

Six hours of recovery time is included in the minute value. The time the anesthesiologist spends with the patient in the recovery room is not counted. Sheath removal and hemostasis is considered part of recovery and is not to be counted.

The cost of sedation and pain reducing drugs used to make a procedure more easily tolerated are not included in the IRC rate center. The time it takes to administer the drugs is accounted for in counting the procedure minutes. Revenue and expenses associated with the drug itself are billed and reported through the Pharmacy rate center.

DRAFT Recommendation for the Readmissions Reduction Incentive Program for Rate Year 2019

April 12, 2017

Health Services Cost Review Commission

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document contains the draft staff recommendations for updating the Maryland Hospital Readmissions Reduction Incentive Program (RRIP), for RY 2019. Please submit comments on this draft to the Commission by Friday, April 21, 2017, via hard copy mail or e-mail to hscrc.quality@maryland.gov.

Contents

List of Abbreviations 3
Introduction 4
Background 4
  Medicare Hospital Readmissions Reduction Program 4
  Overview of the Maryland RRIP Program 5
Assessment 7
  Maryland's Performance to Date 7
    Medicare Waiver Test Performance 7
    All-Payer Performance 8
    CMMI and HSCRC Readmission Rate Differences 9
  Improvement Target Calculation Methodology for Rate Year 2019 9
  Attainment Target Calculation Methodology for RY 2019 12
    Out-of-State Adjustment 13
    Risk-Adjusting of Attainment Target 13
  Prospective Scaling for RY 2019 Policy 13
    Improvement Scale 14
    Attainment Scale 14
Recommendations 15
Appendix I. HSCRC Current Readmissions measure specifications 16
Appendix II. CMS Medicare Readmission Test modifications - Versions 5 and 6 20
Appendix III. All-Payer Hospital-Level Readmission Rate Change CY 2013-2016 21
Appendix IV. RY 2019 Improvement and Attainment Scaling – Modeled Results 22
Appendix V. Out-Of-State Medicare Readmission Ratios 26
Appendix VI. Mathematica Policy Research – RRIP Modeling 29

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
APR-DRG	All-patient refined diagnosis-related group
ARR	Admission-Readmission Revenue Program
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
ICD-10	International Classification of Disease, 10th Edition
PAU	Potentially avoidable utilization
PQI	Prevention quality indicator
RRIP	Readmissions Reduction Incentive Program
RSSP	Readmissions Shared Savings Program
RY	Rate year
SOI	Severity of illness
YTD	Year-to-date

INTRODUCTION

The purpose of this report is to make recommendations for updating the Readmissions Reduction Incentive Program (RRIP) for the state rate year (RY) 2019 methodology.

The draft recommendation updates the readmission reduction targets for RY 2019 in order to align with the All-Payer Model's readmission reduction target for Calendar Year (CY) 2018, and also includes the following policy elements:

- Updates the base period for the RY 2019 RRIP to fall under the International Classification of Disease, 10th Edition (ICD-10) time period;
- Evaluates Calendar Year 2016 year-to-date (YTD) performance versus the All Payer Agreement requirements, and recommends Medicare improvement targets to ensure continued progress; and
- Develops all-payer targets for attainment and improvement with established preset rewards/penalties scales for RY 2019 RRIP hospital revenue adjustments.

BACKGROUND

Medicare Hospital Readmissions Reduction Program

The United States health care system currently has an unacceptably high rate of preventable hospital readmissions. These excessive readmissions generate considerable unnecessary costs and substandard care quality for patients. A readmission is defined as an admission to a hospital within a specified time period after a discharge from the same or another hospital. Under authority of the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) established its Medicare Hospital Readmissions Reduction Program (HRRP) in federal fiscal year (FFY) 2013. Under this program, CMS calculates the average risk-adjusted, 30-day hospital readmission rates for patients with certain conditions using claims data. If a hospital's risk-adjusted readmission rate for such patients exceeds that average, CMS penalizes it in the following year for all Medicare admissions; the penalty is in proportion to the hospital's rate of excess readmissions. Penalties under the HRRP were first imposed in FFY 2013, during which the maximum penalty was 1 percent of the hospital's base inpatient claims. The maximum penalty increased to 2 percent for FFY 2014 and 3 percent for FFY 2015 and beyond. CMS uses three years of previous data to calculate each hospital's readmission rate. For penalties in FFYs 2013 and 2014, CMS focused on readmissions occurring after initial hospitalizations for three conditions: heart attack, heart failure, and pneumonia. For penalties in FFY 2015, CMS included two additional conditions: chronic obstructive pulmonary disease and elective hip or knee replacement. In the future, CMS intends to continue with these conditions and will add the

assessment of performance following initial diagnosis of coronary artery bypass graft surgery to the list for FFY 2017.[1]

Overview of the Maryland RRIP Program

Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal HRRP. The ACA requires Maryland to have a similar program, and to achieve the same or better results in costs and outcomes in order to maintain this exemption. The Health Services Cost Review Commission (HSCRC, or "Commission") made an initial attempt to encourage reductions in unnecessary readmissions when it created the Admission-Readmission Revenue (ARR) program in RY 2012. The ARR program, which was adopted by most Maryland hospitals, established "charge per episode" constraints on hospital revenue, providing strong financial incentives to reduce hospital readmissions. In RY 2014, global budgets supplanted the charge per case system, and the ARR program was replaced with a Readmissions Shared Savings Policy (RSSP). The RSSP was adopted to achieve savings that would be approximately equal to those that would have been expected from the federal Medicare HRRP. From RY 2014 to RY 2016, the HSCRC RSSP decreased hospital inpatient revenues by an average annual savings of 0.20 percent of total revenue, resulting in a cumulative average savings of 0.60 percent of total revenue through RY 2016. In RY 2017, the Commission expanded the savings policy to include potentially avoidable utilization (PAU), and increased the total reduction percentage to 1.25% of total revenue.[2]

The All-Payer Model Agreement with CMS replaced the requirements of the ACA by establishing two sets of requirements to maintain exemptions from federal programs for readmissions and hospital-acquired conditions. One set of requirements established performance targets for readmissions and complications, while the second set of requirements ensured that the amount of revenue adjustments in Maryland's quality-based programs matches CMS levels in aggregate. For readmissions, Maryland's Medicare fee-for-service (FFS) statewide hospital readmission rate must be equal to or below the national Medicare readmission rate by CY 2018. Maryland must also make annual progress toward this goal.

In order to meet the new Model requirements, the Commission approved a new readmissions program in April 2014—the RRIP—to further bolster the incentives to reduce unnecessary readmissions. The Performance Measurement Work Group established the following guiding principles for the RRIP:

- The measurements used for performance linked with payment must include all patients, regardless of payer.

---

[1] For more information on HRRP, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.

2 The PAU savings adjustment is the percentage of hospital inpatient revenue the state expects to save through reducing potentially avoidable utilization, defined as readmissions and Prevention Quality Indicators (PQIs)

- The measurements must be fair to hospitals.
- Annual targets must be established to reasonably support the overall goal of meeting or outperforming the national Medicare readmission rate by CY 2018.
- The measurements used should be mostly consistent with the CMS readmissions measure.
- The approach must include the ability to track progress.

The RRIP provided a positive increase of 0.50 percent of inpatient revenues in RY 2016 for hospitals that were able to meet or exceed a pre-determined reduction target for readmissions in CY 2014 relative to CY 2013. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI) (see Appendix I for details of indirect standardization method). The readmissions reduction target was set at 6.76 percent of for all-payer case-mix adjusted readmission rates.[3] The HSCRC did not impose penalties in the first year of the RRIP program.

As progress in reducing readmissions was slower than projected in CY 2014, the RRIP methodology was updated for RY 2017 to include both higher potential rewards for hospitals that achieved or exceeded the readmission reduction target, as well as established penalties for hospitals that did not achieve the required readmission reductions. Rewards and payment reductions were allocated along a linear scale commensurate with hospital improvement rates. The readmission reduction target for RY 2017 was set at 9.30 percent from CY 2013 all-payer case-mix adjusted readmission rates.[4] In RY 2018, staff updated the policy to include an attainment target to reward hospitals that achieve readmission rates lower than the 25th percentile of statewide rates, which in RY 2018 was projected to be 11.85 percent.[5] The reduction target for RY 2018 was set at 9.50 percent from CY 2013 all-payer case-mix adjusted readmission rates.[6] The cumulative 9.50% reduction in readmissions CY 2016 over CY 2013 is less than the Commission initially expected it to be, since national readmissions *increased* in CY 2014, declined back to CY 2013 levels in CY 2015, and only began improving more quickly in CY 2016.

---

[3] This target was based on the excess levels of Medicare readmissions in Maryland in CY 2013 (8.78 percent), divided by five (representing each year of the Model Agreement performance period), plus an estimate of the reduction in Medicare readmission rates that would be achieved nationally (5.00 percent)

[4] The target was updated based on remaining national Medicare readmission rates and a projected 1.34 percent decline in the national Medicare readmission rates in CY 2015.

[5] The All-Payer Casemix-Adjusted Readmission Rate used in the Attainment Target calculation is adjusted for out-of-state readmissions. This attainment benchmark was also retrospectively applied to RY 2017 RRIP policy.

[6] The target was updated based on remaining Medicare readmission rates and a projected 0.80% decline in the national Medicare readmission rates in CY 2016 (see Figure 3 of RY 2018 RRIP policy).

ASSESSMENT

In order to refine the methodology for RY 2019, the HSCRC has solicited input from the Performance Measurement Workgroup, and staff has worked extensively with contractors to model the readmission rate improvement needed to achieve the All-Payer Model Waiver Test. The Workgroup has discussed pertinent issues and potential changes to Commission policy for RY 2019, and has reviewed the most recent performance data available.

Maryland's Performance to Date

Medicare Waiver Test Performance

At the onset of the All-Payer Model Agreement, HSCRC and CMS staff worked to refine the Medicare readmission measure specifications used to determine contract compliance. These changes narrowed the gap between the Maryland and national Medicare readmission rates to 7.93 percent for CY 2013 (or 1.22 percentage points), as the original estimates included planned admissions. The original logic also included specially-licensed rehabilitation and psychiatric beds for Maryland, but not for the nation (see Appendix II for details). Final calculations indicate that Maryland's Medicare readmission rate was 16.60 percent, compared with the national rate of 15.38 percent for CY 2013.

Using the revised final measurement methodology, Maryland performed better than the nation in reducing readmission rates in both CY 2014 and CY 2015, as well as CY 2016 YTD through November. The Model Agreement requires Maryland to make annual progress by reducing the gap by one-fifth each year, while keeping up with national reductions, to ensure Maryland's readmission rates are at or below the national level by the end of CY 2018. Figures 1 and 2 provide the calculations for this test and present results for CY 2014, CY 2015, and CY2016 projections.

Due to the claims lag in the Medicare data, the draft policy presents a 12-month trend of readmission declines, using data from December 2015 through November 2016. During these 12 months, Maryland continued to reduce readmissions more rapidly than the nation. However, the nation reduced its readmissions rate more rapidly in CY 2016 than in prior years. Therefore, Maryland will need to factor this more rapid readmission reduction into its improvement target.

Figure 1 shows the calculations for determining the annual reduction required to close the gap between the Maryland and national Medicare readmission rates, as required by the All-Payer Model Agreement. Figure 2 shows the calculations for determining Maryland's progress in meeting the readmissions reduction target. Maryland is required to close the gap by 0.24 percentage points each year. For CY 2016 (three years into the readmissions test) the gap between Maryland and the nation must be equal to or less than 0.49 percentage points; based off

of CY 2016 annualized projections, Maryland is meeting this goal, as the gap is estimated to be 0.31 percentage points.[7]

Figure 1. All-Payer Model Maryland Medicare Readmissions Test – Gap Closure Requirement

CY 2013 National Medicare Readmission Rate	A	15.38%
CY 2013 MD Medicare Readmission Rate	B	16.60%
MD vs National Difference*	C=B-A	1.22%
Annual Reduction needed to Close the Gap	D=C/5	0.24%

Figure 2. All-Payer Model Maryland Medicare Readmissions Test – Maryland Progress to-date

Calendar Year	National Rate	MD-National Required Difference	MD Required Rate	MD Actual Rate	MD-National Difference
E	F	G=C -(D*Year X)	H=F+G	I	J=I-F
CY 2014	15.49%	**0.98%**	16.47%	16.46%	**0.97%**
CY 2015	15.42%	**0.74%**	16.15%	15.95%	**0.53%**
CY 2016 – Projection based on annualized data	15.32%	**0.49%**	15.80%	15.63%	**0.31%**

*Percentages are rounded up to two decimal points in the tables.

All-Payer Performance

While the CMS readmission waiver test is based on the unadjusted readmission rate for Medicare patients, the RRIP incentivizes performance improvement on the all-payer case-mix adjusted readmission rate. The All-Payer readmission rate reduction incentives align with the guiding principles and all-payer approach used in pay-for-performance programs in Maryland. The RRIP

[7] The stated 0.32% gap in the national-state readmission rates is projected using an annualizing formula based on trends through November of 2016, the most recent data available at the time staff drafted target calculations.

measure incorporates many of the elements of the CMS Medicare measure specifications (e.g., planned admissions), but also retains some differences (e.g., inclusion of psychiatric patients). See Appendix I for more details on the RRIP methodology.

Using preliminary CY 2016 data, the State achieved a 10.79% reduction in the all-payer case-mix adjusted readmission rate in CY 2016 compared to CY 2013, and 28 hospitals are on track to achieve the hospital improvement benchmark of at least a 9.50 percent readmission rate reduction. Since the incentive program also includes an attainment target, an additional 8 hospitals are on track to achieve the attainment goal of a readmission rate lower than 11.85 percent.[8] Appendix III provides preliminary hospital-level improvement rates for CY 2016.

CMMI and HSCRC Readmission Rate Differences

Beginning in CY 2016, and concurrent with the ICD-10 transition, HSCRC Medicare FFS readmissions improvement trends began to diverge from CMS Medicare FFS readmissions data. In understanding the ICD-10 impact, HSCRC and CMS noted that CMS' rehab exclusion was no longer properly excluding rehab cases under ICD-10. CMS revised the methodology for identifying rehab cases for exclusion; however, this update did not rectify the CMS-HSCRC divergence.

HSCRC staff has also tried to replicate the Center for Medicare and Medicaid Innovation (CMMI) methodology with the HSCRC data (e.g., removing psychiatric admissions and transfer logic differences). While the differences between the trends are attenuated, a substantial difference in readmission rate improvement trends remains. HSCRC staff and contractors continue to research potential reasons for this divergence, but the data discrepancy adds an additional layer of uncertainty to current projections, and may need to be accounted for in the improvement target calculated below.

Improvement Target Calculation Methodology for Rate Year 2019

As previously stated, Maryland is required to close one-fifth of the gap between the national and Maryland readmission rates, and to match the national decline in Medicare readmission rates each year. Although one-fifth of the National-Maryland gap in CY 2013 is 0.24 percentage points, it is challenging to predict national readmission rates and to set targets for the state prospectively. Furthermore, additional adjustment factors are necessary to convert the Medicare unadjusted readmission target to an all-payer case-mix adjusted target. HSCRC contractor Mathematica Policy Research modeled different specifications to predict national readmission rates. The target calculation models for CY 2017 assume that Maryland would match the annual decline in the national Medicare readmission rate, close half of the remaining gap between the

[8] Again, the All-Payer Casemix-Adjusted Readmission Rate used in the Attainment Target calculation is adjusted for out-of-state readmissions.

Maryland and national rates, and then converts the target from an unadjusted Medicare readmission rates to an all-payer case-mix adjusted readmission rate.

Due to the transition to ICD-10, HSCRC is shifting the base period forward, so that both base period (CY 2016) and the performance period (CY 2017) are under ICD-10 coding. As such, a hospital improvement target will be calculated for CY 2017 compared to CY 2016. However, a re-based annual target could improperly shift improvement incentives from the hospitals that made early investments to reduce readmissions. Therefore, the CY 2016-2017 annual improvement target will be added to the cumulative statewide improvement in readmissions achieved in CY 2013-CY 2016 (RY 2018 case-mix adjusted readmission improvement) to calculate a **modified cumulative target**. Under a modified cumulative target, some hospitals that have already achieved substantial improvements in readmissions rates may have less incentive to continue to improve. However, staff notes that the statewide improvement target is based on all hospitals continuing to improve, and under the proposed targets, nearly all hospitals will have incentive to improve in order to maximize their reward.

The State will plan to reduce the remaining gap evenly over the last two years of the Model period. The targeted gap between the national and Maryland Medicare readmission rates by the end of CY 2017 would therefore be 0.16 percentage points (see Figure 3).

Figure 3. Calculation of the Readmissions Target Gap for CY 2017

CY 2016 National Medicare Readmission Rate (projected)	A	15.30%
CY 2016 MD Medicare Readmission Rate (projected)	B	15.62%
MD vs. National Difference (projected)	C=B-A	0.32%
Annual Gap Reduction needed to Close the Gap	D=C/2	0.16%
CY 2017 Target Gap	E=C-D	0.16%

Next, staff and their contractors considered different assumptions for estimating the National Medicare readmission rates in CY 2017 and CY 2018. Mathematica modeled multiple projections of the national reduction rate including average annual change, change from 2015 to 2016, and 12- and 24-month moving averages (Appendix VI). Maryland only has two years left to reach the national readmissions rate, and must keep up with any national reduction in addition to eliminating the remaining gap. Staff will therefore assume that the most conservative of the Mathematica models (i.e., the largest decrease) will represent the National Medicare readmission rate. Based on this model, the national readmission rate is projected to decline by 0.80 percent annually; however, Mathematica also modeled projections using a 1 percent and 1.5 percent decline due to fluctuations over the last three months in the CY 2016 decline (which was 1.06 percent based on September data). Figure 4 calculates the MD Medicare Readmission Target Rate (Column D) and Reduction Target (Column E) based on these three estimates of the projected decline in the national readmission rate. Based on these projections of the National rate, the required Maryland Medicare readmission reduction ranges from 1.83 to 2.51 percent in CY 2017 compared to CY 2016.

Figure 4. Calculation of Required Maryland Medicare FFS Rate for CY 2017

Estimated National Decline	National	MD-National Target Gap	MD Readmission Target Rate	MD Annual Readmission Reduction Target
A	B=15.30%*(1+A)	C	D=B+C	E=D/15.62-1
-0.80%	15.17%	0.16%	15.33%	-1.83%
-1.00%	15.14%	0.16%	15.30%	-2.02%
-1.50%	15.07%	0.16%	15.23%	-2.51%

The final step in calculating the RRIP target, illustrated in Figure 5, is to convert the Medicare target to an all-payer reduction target. The all-payer adjustment was previously modeled using the simple difference between the change over time in the Medicare and all-payer readmission rates (Method 1 in Figure 5 below). Mathematica has also modeled the Medicare to All-Payer conversion using the simple ratio of the difference between the rates of change of the Medicare and All-Payer rates (Method 2), as well as using a monthly regression model of the ratios of change (Method 3). Figure 5 below presents the All-Payer reduction targets for the 3 options, assuming a National Medicare reduction of -0.8%, -1.0%, and -1.5%. For more details on how these reduction targets are calculated, please refer to Appendix VI.

Given the variability in these projections, staff is proposing an improvement target that is an approximate midpoint of the various projections presented in Figure 4. Staff continue to vet these options with stakeholders, but for the purposes of this draft recommendation, staff is proposing a reduction target of -4.0% in the case-mix adjusted readmission rate, CY 2017 over CY 2016. Staff is further recommending that this improvement target be added to hospitals' previous improvement of approximately 11%, for an aggregated improvement target of -15.0% through CY 2017.

Figure 5. Calculations for Converting the Medicare Reduction Target to an All-Payer Target

National Projected Reduction Rate for CY 2017	-0.80%	-1.00%	-1.50%
Method 1: Add difference in rates of change to FFS target (-5.06%)	-6.90%	-7.09%	-7.58%
Method 2: Use ratio of changes in rates to scale FFS target (0.539)	-3.42%	-3.77%	-4.68%
Method 3: Use regression-based factor to scale FFS Target (0.61)	-3.02%	-3.33%	-4.14%

In establishing a one-year improvement target for the RRIP for RY 2019 (CY 2017 over CY 2016), staff notes that it is important to strike a reasonable balance between the desire to set a target that is not unrealistically high and the need to conform to the requirements of the Model Agreement. While some stakeholders have expressed concerns regarding the increase in the target from 9.5% to 15%, staff believe that with each passing year, underachievement in any

particular year becomes increasingly hard to offset in the remaining years. Again, the consequence for not achieving the minimum annual reduction would be a corrective action plan and potentially the loss of the waiver from the Medicare HRRP. The consequences of not meeting the target are stated in the Model Agreement as follows:

> *If, in a given Performance Year, Regulated Maryland Hospitals, in aggregate, fail to outperform the national Readmissions Rate change by an amount equal to or greater than the cumulative difference between the Regulated Maryland Hospitals and national Readmission Rates in the base period divided by five, CMS shall follow the corrective action and/or termination provisions of the Waiver of Section 1886(q) as set forth in Section 4.c and in Section 14.*

Requiring Maryland to conform to the national Medicare HRRP would reduce our ability to design, adjust, and integrate our reimbursement policies consistently across all payers based on local input and conditions. In particular, the national program is structured as a penalty-only system based on a limited set of conditions, whereas the Commission prefers to have the flexibility to implement much broader incentive systems that reflect the full range of conditions and causes of readmissions on an all-payer basis.

Attainment Target Calculation Methodology for RY 2019

In RY 2018, staff added a new component to the RRIP methodology to provide rewards or penalties contingent upon the level of readmission rates, based on a statewide readmission attainment target (benchmark), similar to the current policy which sets an improvement target. Individual hospitals' performance relative to the statewide target would be tied to specific payment adjustment amounts, and hospitals would be evaluated on both attainment and improvement. The hospital's final payment adjustment would be based on the "better of" the two adjustments.

In the RY 2018 RRIP policy, staff set the attainment benchmark at the unweighted lowest 25th percentile for the year prior to the performance period, and prospectively adjusted this percentile downward to account for the continuous improvement needed to achieve the All-Payer Model waiver test. Consistent with RY 2018 attainment rate calculations, the lowest 25th percentile for CY 2016 Case-Mix Adjusted Readmissions Rates (adjusted for Out-of-State Readmissions) is 11.05%. Mirroring the 2% improvement factor from RY 2018, staff decreased the 11.05% by an additional 2 percent to further incentivize the continuous improvement needed to meet the All-Payer Model Waiver test. This 2 percent reduction yields an attainment target of 10.83% for CY 2017. Figure 6 provides the distribution of CY 2016 readmission rates.

Figure 6. CY 2017 All-Payer Readmission Rates and Estimated National Average

		CY 2016 Case-Mix Adjusted Readmission Rates Adjusted for Out-of-State Readmissions
Lowest Readmission Rate	A	7.18%
Lowest 25th percentile	B	11.05%
State Average	C	11.85%

		CY 2016 Case-Mix Adjusted Readmission Rates Adjusted for Out-of-State Readmissions
Highest 25th percentile	D	12.54%
Highest Readmission Rate	E	14.90%

* Medicare out-of-state readmissions are used for adjustments.

Out-of-State Adjustment

As a continuation from the RY 2018 RRIP policy, staff worked with the Performance Measurement Workgroup to account for out-of-state readmissions, so as to account for readmission rates for border hospitals. Without such an adjustment, border hospitals appear to have lower readmissions that do not include readmissions to non-Maryland hospitals. Each month, HSCRC uses data from CMMI to create a ratio of out-of-state readmissions (Total Readmissions/In-State Readmissions), based on the most recent 12 months of data. Then, this ratio is applied to the case-mix adjusted readmissions rates to estimate an adjusted readmission rate that more accurately estimates border hospital readmissions.

Risk-Adjusting of Attainment Target

As in previous years, some stakeholders have raised concerns with the RRIP case-mix adjustment. In particular, some stakeholders feel the current model does not adequately risk-adjust for socioeconomic status disparities. At this time, the HSCRC maintains that the State's case-mix adjustment sufficiently addresses case-mix differences among hospitals. Furthermore, the HSCRC staff continue to be concerned about adjusting for socio-demographic factors, so long as hospitals with higher socio-demographic burden are able to achieve favorable improvement results and are not being unduly penalized by the policies. However, Maryland will continue to revisit this issue in future years as it continues to adjust attainment scales.

Prospective Scaling for RY 2019 Policy

As always, staff carefully considered projected score distribution and reduction target feasibility to determine a prospective scale for both improvement and attainment targets for RY 2019. These scales are subject to change in the final RY 2019 RRIP policy, and have been built upon improvement and attainment targets using the most recent data modeling. The scaling models use the improvement and attainment targets as the inflection point, where hospitals that score exactly the improvement or attainment target will not experience a revenue adjustment. The improvement scale calculates the 10th percentile of most-recent hospital improvement scores, and uses this number as the threshold for the 1 percent maximum reward. For the attainment scale, the 10th percentile readmission rate for CY 2016 (with a 2% improvement adjustment) is used as the threshold for the maximum 1 percent reward. Based on the two data points (the inflection point of zero revenue adjustments, and the maximum reward), the rest of the scaling is extrapolated using a linear scale to reach the rates at which the maximum penalties of -2% are applied.

Improvement Scale

The current improvement scale uses an inflection point of the -15.0% modified cumulative improvement target, and provides potential negative revenue adjustments up to 2 percent and potential positive adjustments up to 1 percent.

Figure 7. RY 2019 Abbreviated Cumulative Improvement Scale

All Payer Readmission Rate Change CY13-CY17	Over/Under Target	RRIP % Inpatient Revenue Payment Adjustment
A	B	C
Better Improvement		1.0%
-25.5%	-10.5%	1.0%
-20.3%	-5.3%	0.5%
-15.0%	0.0%	0.0%
-9.7%	5.3%	-0.5%
-4.5%	10.5%	-1.0%
0.8%	15.8%	-1.5%
6.0%	21.0%	-2.0%
Worse Improvement		-2.0%

Attainment Scale

The current attainment scale uses an inflection point of the 10.83% attainment target, and provides potential negative revenue adjustments up to 2 percent and potential positive adjustments up to 1 percent.

Figure 8. RY 2019 Abbreviated Attainment Scale

All Payer Readmission Rate CY17	Over/Above Target From Target	RRIP % Inpatient Revenue Payment Adjustment
A	B	C
LOWER Readmission Rate		1.0%
9.92%	-0.9%	1.0%
10.38%	-0.5%	0.5%
10.83%	0.0%	0.0%
11.29%	0.5%	-0.5%
11.74%	0.9%	-1.0%
12.20%	1.4%	-1.5%
12.65%	1.8%	-2.0%

Higher Readmission Rate		-2.0%

RECOMMENDATIONS

Based on this assessment, HSCRC staff recommends the following updates to the RRIP program for RY 2019:

1. The RRIP policy should continue to be set for all-payers.
2. Hospital performance should continue to be measured as the better of attainment or improvement.
3. Due to ICD-10, RRIP should have a one-year improvement target (CY 2017 over CY 2016), and will add this one-year improvement to the achieved improvement CY 2016 over CY 2013, to create a modified cumulative improvement target.
4. The attainment benchmark should be set at 10.83 percent.
5. The reduction benchmark for CY 2017 readmissions should be -4.0% percent from CY 2016 readmission rates.

In the interim between the draft and final recommendations, staff will work with stakeholders and consultants to reach consensus on improvement and attainment targets, as well as properly calibrated prospective scaling for the RY 2019 policy.

APPENDIX I. HSCRC CURRENT READMISSIONS MEASURE SPECIFICATIONS

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra and inter hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.

The measure is similar to the readmission rate that will be calculated for the new All-Payer Model with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients and excludes oncology admissions. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, adjustments had to be made to the metric that accounted for planned admissions and SOI. See below for details on the readmission calculation for the RRIP program.

2) Adjustments to Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs rather than principal diagnosis (APR-DRGs 540, 541, 542, 560, 860). Planned admissions are counted in the denominator because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.
- Oncology cases are removed prior to running readmission logic.
- Rehabilitation cases as identified by APR-860 (which are coded after under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission but can be a readmission for a previous admission.
- Hospitalizations within 30 days of a hospital discharge where a patient dies is counted as a readmission, however the readmission is removed from the denominator because there cannot be a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator counts. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital. It is this discharge date that is used to calculate the 30-day readmission window.
- Discharges from rehabilitation hospitals (provider IDs Chesapeake Rehab 213028, Adventist Rehab 213029, and Bowie Health 210333) are removed.
- Holy Cross Germantown 210065 (attainment only) and Levindale 210064 are included in the program; and
- Starting Jan 2016, HSCRC is receiving information about discharges from chronic

beds within acute care hospitals with the same data submissions. These discharges were excluded from RRIP for RY 2018.

- In addition, the following data cleaning edits are applied:
  - Cases with null or missing Chesapeake Regional Information System for our Patients (CRISP) unique patient identifiers (EIDs) are removed.
  - Duplicates are removed.
  - Negative interval days are removed.
  - HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:
To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, plus an additional 30 days. To calculate the case-mix adjusted readmission rate for CY 2016 base period and CY 2017 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used.

SOFTWARE: APR-DRG Version 34 (ICD-10) for CY 2016-CY 2017.

Calculation:

$$\text{Risk-Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} * \text{Statewide Readmission Rate}$$

Numerator: Number of observed hospital-specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

- Calculate the Statewide Readmission Rate without Planned Readmissions.
  - Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

- For each hospital, calculate the number of observed, unplanned readmissions.
- For each hospital, calculate the number of expected unplanned readmissions based upon discharge APR-DRG SOI (see below for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data (CY 2016).
- Calculate the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.
- Multiply the O/E ratio by the statewide rate to get risk-adjusted readmission rate by hospital.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals, given its mix of patients as defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being "at-risk" for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm
P = Number of discharges with a readmission
D = Number of discharges that can potentially have a readmission
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms can be applied to each hospital. In this example, the computation presents expected readmission rates for an individual APR-DRG category and its SOI levels. This computation could be expanded to include multiple APR-DRG categories or any other subset of data, by simply expanding the summations.

Consider the following example for an individual APR DRG category.

Expected Value Computation Example

1 Severity of Illness Level	2 Discharges at Risk for Readmission	3 Discharges with Readmission	4 Readmissions per Discharge	5 Normative Readmissions per Discharge	6 Expected # of Readmissions
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the APR-DRG category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column 3). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of discharges with a readmission (sum of column 3) by the total number of discharges at risk for readmission (sum of column 2), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each SOI level for that APR-DRG category is displayed in column 5. The expected number of readmissions for each SOI level shown in column 6 is calculated by multiplying the number of discharges at risk for a readmission (column 2) by the normative readmissions per discharge rate (column 5) The total number of readmissions expected for this APR-DRG category is the sum of the expected numbers of readmissions for the 4 SOI levels.

In this example, the expected number of readmissions for this APR-DRG category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this APR-DRG category. This difference can also be expressed as a percentage.

APR-DRGs by SOI categories are excluded from the computation of the actual and expected rates when there are only zero or one at risk admission statewide for the associated APR-DRG by SOI category.

APPENDIX II. CMS MEDICARE READMISSION TEST MODIFICATIONS - VERSIONS 5 AND 6

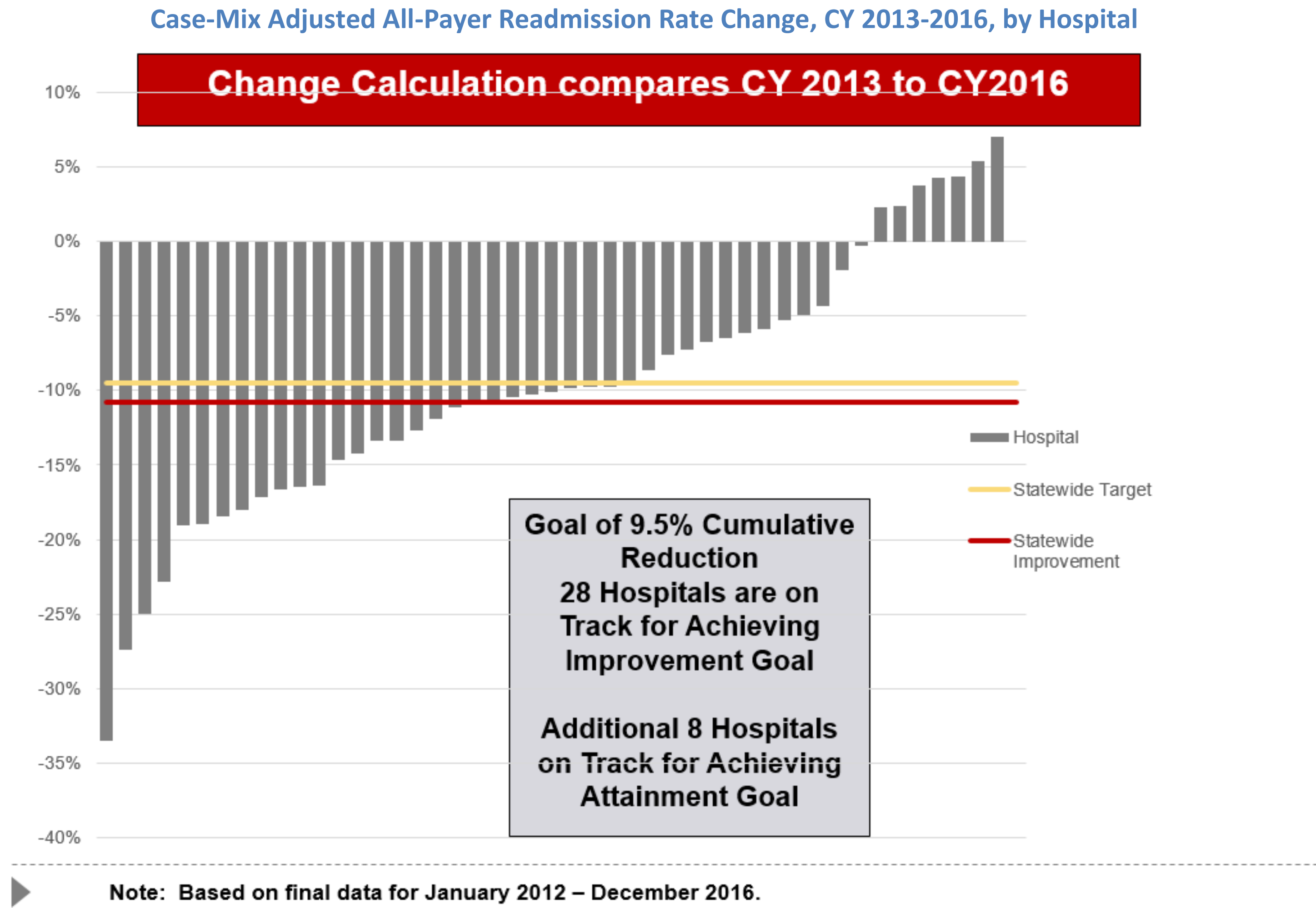
In last year's policy, HSCRC included an itemized list of changes in version 5 of the CMS Medicare Readmission Test. These changes are listed below as a reminder. Beginning in CY 2016, the rehabilitation discharges are identified using UB codes to account for definition changes under ICD-10.

Below are the specification changes made to allow an accurate comparison of Maryland's Medicare readmission rates with those of the nation.

- Requiring a 30-day enrollment period in fee-for-service (FFS) Medicare after hospitalization to fully capture all readmissions.
- Removing planned readmissions using the CMS planned admission logic for consistency with the CMS readmission measures.
- Excluding specially-licensed rehabilitation and psychiatric beds from Maryland rates due to inability to include these beds in national estimates due to data limitations. In contrast, the HSCRC includes psychiatric and rehabilitation readmissions in the all-payer readmission measure used for payment policy.
    - Version 6 of the CMS measure changed to using UB codes to identify rehabilitation discharges due to ICD-10.
- Refining the transfer logic to be consistent with other CMS readmission measures.
- Changing the underlying data source to ensure clean data and inclusion of all appropriate Medicare FFS claims (e.g., adjusting the method for calculating claims dates and including claims for patients with negative payment amounts).

APPENDIX III. ALL-PAYER HOSPITAL-LEVEL READMISSION RATE CHANGE CY 2013-2016

The following figure presents the change in all-payer case-mix adjusted readmissions by hospital between CY 2013 and CY 2016.



APPENDIX IV. RY 2019 IMPROVEMENT AND ATTAINMENT SCALING – MODELED RESULTS

The following figure presents the proposed RY 2019 model scaling, using RY 2018 readmission rate results. Columns A and B show the hospital's actual case-mix adjusted readmission rates for CYs 2013 and 2016 respectively; column C shows the actual case-mix adjusted rate with out-of-state adjustment for CY 2016. Column D shows the percent change in in-state actual case-mix adjusted readmission rates between CY 2016 and CY 2013. Columns E through H present the scaling results using the proposed RY 2019 cumulative improvement methodology, and columns I through L present the scaling results using the proposed RY 2019 attainment methodology. Column M shows the revenue adjustment that is the better of attainment or improvement. (FY 2017 Permanent Global Budgets and Readmission Rates, used to calculate the revenue adjustments, may be updated in the final recommendation). The modeled results for RY 19 using CY 2016 actual data show an overall negative adjustment. This is expected, since the proposed policy requires an improvement beyond the actual CY 2016 results.

					Improvement Scaling				Attainment Scaling				Final Adj
Hospital Name	**CY 13 Case-Mix Adjusted Rate**	**CY 16 Case-Mix Adjusted Rate**	**CY 16 Case-Mix Adjusted Rate Adjusted for Out of State**	**% Change In In-state Case- Mix Adjusted Rate**	**Target**	**Over/ Under Target**	**FY 18 Scaling**	**FY 18 Adjustment**	**Target**	**Over/ Under Target**	**FY 18 Scaling**	**FY 18 Adjustment**	**FY18 Better of Attainment/ Improvement**
	A	B	C	D=B/A-1	E	F = D-E	G	H	I	J	K	L	M = (H or L)
Anne Arundel	12.10%	10.95%	11.45%	-9.50%	-15.0%	5.5%	-0.52%	-$1,550,196	10.83%	5.7%	-2.00%	-$5,923,379	**-$1,550,196**
Atlantic General	11.91%	8.93%	10.17%	-25.02%	-15.0%	-10.0%	0.95%	$371,884	10.83%	-6.1%	1.00%	$389,660	**$389,660**
Baltimore Washington	14.16%	12.27%	12.45%	-13.35%	-15.0%	1.7%	-0.16%	-$357,893	10.83%	14.9%	-2.00%	-$4,547,989	**-$357,893**
Bon Secours	19.10%	14.74%	14.94%	-22.83%	-15.0%	-7.8%	0.75%	$462,241	10.83%	38.0%	-2.00%	-$1,240,166	**$462,241**
Calvert	9.82%	8.83%	10.02%	-10.08%	-15.0%	4.9%	-0.47%	-$296,611	10.83%	-7.4%	1.00%	$633,200	**$633,200**
Carroll County	12.18%	11.13%	11.50%	-8.62%	-15.0%	6.4%	-0.61%	-$707,863	10.83%	6.2%	-2.00%	-$2,330,208	**-$707,863**
Charles Regional	11.79%	9.55%	11.10%	-19.00%	-15.0%	-4.0%	0.38%	$260,467	10.83%	2.5%	-2.00%	-$1,367,741	**$260,467**
Chestertown	13.21%	13.70%	14.70%	3.71%	-15.0%	18.7%	-1.78%	-$338,355	10.83%	35.7%	-2.00%	-$379,782	**-$338,355**
Doctors Community	12.78%	11.45%	12.53%	-10.41%	-15.0%	4.6%	-0.44%	-$502,841	10.83%	15.7%	-2.00%	-$2,299,019	**-$502,841**
Dorchester	11.38%	11.87%	12.29%	4.31%	-15.0%	19.3%	-1.84%	-$445,993	10.83%	13.5%	-2.00%	-$485,131	**-$445,993**

					Improvement Scaling				Attainment Scaling				Final Adj
Hospital Name	CY 13 Case-Mix Adjusted Rate	CY 16 Case-Mix Adjusted Rate	CY 16 Case-Mix Adjusted Rate Adjusted for Out of State	% Change In In-state Case- Mix Adjusted Rate	Target	Over/ Under Target	FY 18 Scaling	FY 18 Adjustment	Target	Over/ Under Target	FY 18 Scaling	FY 18 Adjustment	FY18 Better of Attainment/ Improvement
Easton	10.56%	10.81%	11.19%	2.37%	-15.0%	17.4%	-1.65%	-$1,654,050	10.83%	3.3%	-2.00%	-$2,000,011	**-$1,654,050**
Franklin Square	12.94%	12.38%	12.52%	-4.33%	-15.0%	10.7%	-1.02%	-$2,922,290	10.83%	15.6%	-2.00%	-$5,750,204	**-$2,922,290**
Frederick	10.60%	9.56%	10.15%	-9.81%	-15.0%	5.2%	-0.49%	-$883,825	10.83%	-6.3%	1.00%	$1,788,540	**$1,788,540**
Ft. Washington	13.06%	9.48%	12.22%	-27.41%	-15.0%	-12.4%	1.00%	$193,720	10.83%	12.8%	-2.00%	-$387,440	**$193,720**
G.B.M.C.	11.19%	10.50%	10.70%	-6.17%	-15.0%	8.8%	-0.84%	-$1,821,903	10.83%	-1.2%	1.00%	$2,165,548	**$2,165,548**
Garrett County	7.04%	5.83%	7.80%	-17.19%	-15.0%	-2.2%	0.21%	$45,492	10.83%	-27.9%	1.00%	$218,363	**$218,363**
Good Samaritan	14.46%	11.85%	11.94%	-18.05%	-15.0%	-3.0%	0.29%	$460,604	10.83%	10.2%	-2.00%	-$3,171,584	**$460,604**
Harbor	13.02%	12.14%	12.43%	-6.76%	-15.0%	8.2%	-0.78%	-$845,794	10.83%	14.8%	-2.00%	-$2,155,238	**-$845,794**
Harford	11.53%	12.15%	12.55%	5.38%	-15.0%	20.4%	-1.94%	-$911,655	10.83%	15.9%	-2.00%	-$939,515	**-$911,655**
Holy Cross	11.32%	11.58%	12.49%	2.30%	-15.0%	17.3%	-1.65%	-$5,594,179	10.83%	15.3%	-2.00%	-$6,791,870	**-$5,594,179**
Hopkins Bayview	15.30%	14.19%	14.54%	-7.25%	-15.0%	7.7%	-0.74%	-$2,570,852	10.83%	34.2%	-2.00%	-$6,970,590	**-$2,570,852**
Howard County	11.80%	11.22%	11.39%	-4.92%	-15.0%	10.1%	-0.96%	-$1,691,220	10.83%	5.2%	-2.00%	-$3,521,716	**-$1,691,220**
Johns Hopkins	14.69%	12.83%	13.91%	-12.66%	-15.0%	2.3%	-0.22%	-$3,022,374	10.83%	28.4%	-2.00%	-$27,143,298	**-$3,022,374**
Laurel Regional	13.89%	11.60%	12.49%	-16.49%	-15.0%	-1.5%	0.14%	$84,563	10.83%	15.3%	-2.00%	-$1,194,484	**$84,563**
McCready	11.93%	12.77%	12.77%	7.04%	-15.0%	22.0%	-2.00%	-$58,611	10.83%	17.9%	-2.00%	-$58,611	**-$58,611**
Mercy	14.61%	11.92%	12.20%	-18.41%	-15.0%	-3.4%	0.32%	$702,821	10.83%	12.7%	-2.00%	-$4,325,629	**$702,821**
Meritus	11.80%	11.03%	11.46%	-6.53%	-15.0%	8.5%	-0.81%	-$1,494,543	10.83%	5.8%	-2.00%	-$3,703,478	**-$1,494,543**
Montgomery General	12.45%	10.68%	11.19%	-14.22%	-15.0%	0.8%	-0.07%	-$59,144	10.83%	3.3%	-2.00%	-$1,585,975	**-$59,144**
Northwest	15.07%	12.20%	12.44%	-19.04%	-15.0%	-4.0%	0.39%	$484,165	10.83%	14.8%	-2.00%	-$2,513,924	**$484,165**
Peninsula Regional	11.02%	10.44%	11.03%	-5.26%	-15.0%	9.7%	-0.93%	-$2,185,967	10.83%	1.8%	-2.00%	-$4,714,598	**-$2,185,967**
Prince George	10.67%	10.64%	12.87%	-0.28%	-15.0%	14.7%	-1.40%	-$3,014,010	10.83%	18.8%	-2.00%	-$4,300,217	**-$3,014,010**

					Improvement Scaling				Attainment Scaling				Final Adj
Hospital Name	CY 13 Case-Mix Adjusted Rate	CY 16 Case-Mix Adjusted Rate	CY 16 Case-Mix Adjusted Rate Adjusted for Out of State	% Change In In-state Case- Mix Adjusted Rate	Target	Over/ Under Target	FY 18 Scaling	FY 18 Adjustment	Target	Over/ Under Target	FY 18 Scaling	FY 18 Adjustment	FY18 Better of Attainment/ Improvement
Rehab & Ortho	7.70%	6.88%	7.14%	-10.65%	-15.0%	4.4%	-0.41%	-$44,787	10.83%	-34.0%	1.00%	$108,089	**$108,089**
Shady Grove	10.89%	9.83%	10.39%	-9.73%	-15.0%	5.3%	-0.50%	-$1,100,000	10.83%	-4.0%	1.00%	$2,193,192	**$2,193,192**
Sinai	14.27%	11.90%	12.00%	-16.61%	-15.0%	-1.6%	0.15%	$608,191	10.83%	10.8%	-2.00%	-$7,941,465	**$608,191**
Southern Maryland	11.92%	11.01%	13.78%	-7.63%	-15.0%	7.4%	-0.70%	-$1,145,832	10.83%	27.2%	-2.00%	-$3,266,797	**-$1,145,832**
St. Agnes	13.85%	12.00%	12.08%	-13.36%	-15.0%	1.6%	-0.16%	-$364,738	10.83%	11.5%	-2.00%	-$4,663,030	**-$364,738**
St. Mary	12.69%	10.61%	12.68%	-16.39%	-15.0%	-1.4%	0.13%	$102,455	10.83%	17.0%	-2.00%	-$1,546,920	**$102,455**
Suburban	11.14%	10.92%	11.96%	-1.97%	-15.0%	13.0%	-1.24%	-$2,355,091	10.83%	10.4%	-2.00%	-$3,797,036	**-$2,355,091**
UM St. Joseph	11.76%	10.55%	10.75%	-10.29%	-15.0%	4.7%	-0.45%	-$1,054,321	10.83%	-0.7%	0.77%	$1,798,582	**$1,798,582**
UMMC Midtown	16.69%	14.83%	14.98%	-11.14%	-15.0%	3.9%	-0.37%	-$488,126	10.83%	38.3%	-2.00%	-$2,658,638	**-$488,126**
Union Hospital Of Cecil Count	9.80%	10.22%	13.19%	4.29%	-15.0%	19.3%	-1.84%	-$1,252,268	10.83%	21.8%	-2.00%	-$1,363,581	**-$1,252,268**
Union Memorial	14.35%	12.25%	12.53%	-14.63%	-15.0%	0.4%	-0.03%	-$80,530	10.83%	15.7%	-2.00%	-$4,622,436	**-$80,530**
University Of Maryland	14.39%	12.68%	13.15%	-11.88%	-15.0%	3.1%	-0.30%	-$2,596,481	10.83%	21.5%	-2.00%	-$17,494,551	**-$2,596,481**
Upper Chesapeake	11.59%	10.91%	11.01%	-5.87%	-15.0%	9.1%	-0.87%	-$1,158,159	10.83%	1.7%	-1.84%	-$2,456,619	**-$1,158,159**
Washington Adventist	11.33%	10.11%	11.30%	-10.77%	-15.0%	4.2%	-0.40%	-$604,983	10.83%	4.3%	-2.00%	-$3,001,950	**-$604,983**
Western Maryland	12.41%	11.20%	12.08%	-9.75%	-15.0%	5.2%	-0.50%	-$859,262	10.83%	11.6%	-2.00%	-$3,437,179	**-$859,262**
STATE	**12.93%**	**11.54%**		**-10.75%**	-15.0%			**-$42,258,142**				**-$146,756,825**	**-$28,178,900**

Rehab and Ortho Revenue is adjusted to 16% of total FY 16 Permanent Inpatient Revenue
Percentages have been rounded for display. Final numbers are calculated using full values.

APPENDIX V. OUT-OF-STATE MEDICARE READMISSION RATIOS

The following figure presents calculation of out-of-state ratio adjustments using the Medicare readmission information from CMMI. The table is sorted by column G. Garrett County Hospital has the largest proportion of their readmissions occurring at hospitals outside of Maryland, which is equal to 34 percent of their in-state readmissions. These ratios are updated each month with the most recent 12 months of CMMI data.

Hospital Name	Total Admissions	Total Readmissions	Readmissions Out of Maryland	Readmission Rate	MD Readmission Rate	**Out-of-State (OOS) Ratio**	Case-Mix Adjusted Readmission Rate	Case-Mix Adjusted Rate with OOS Adjustment
A	**B**	**C**	**D**	**E=C/B**	**F**	**G=E/F**	**H**	**I=G*H**
210017 - GARRETT COUNTY	826	83	21	10.05%	7.51%	1.34	5.83%	7.80%
210032 - UNION HOSPITAL OF CECIL COUNTY	2349	373	84	15.88%	12.30%	1.29	10.20%	13.16%
210060 - FT. WASHINGTON	1048	183	41	17.46%	13.55%	1.29	9.48%	12.22%
210062 - SOUTHERN MARYLAND	3631	662	133	18.23%	14.57%	1.25	10.99%	13.75%
210003 - PRINCE GEORGE	2678	474	82	17.70%	14.64%	1.21	10.63%	12.85%
210028 - ST. MARY	2798	411	67	14.69%	12.29%	1.19	10.60%	12.66%
210035 - CHARLES REGIONAL	2534	386	54	15.23%	13.10%	1.16	9.58%	11.14%
210061 - ATLANTIC GENERAL	1878	222	27	11.82%	10.38%	1.14	8.90%	10.13%
210039 - CALVERT	1924	294	35	15.28%	13.46%	1.14	8.85%	10.05%
210016 - WASHINGTON ADVENTIST	2852	427	45	14.97%	13.39%	1.12	10.08%	11.27%
210022 - SUBURBAN	5622	713	62	12.68%	11.58%	1.10	10.90%	11.94%
210051 - DOCTORS COMMUNITY	4210	745	64	17.70%	16.18%	1.09	11.41%	12.48%
210009 - JOHNS HOPKINS	11007	2106	163	19.13%	17.65%	1.08	12.68%	13.74%
210027 - WESTERN MARYLAND HEALTH SYSTEM	5013	767	56	15.30%	14.18%	1.08	11.04%	11.91%
210004 - HOLY CROSS	4707	799	58	16.97%	15.74%	1.08	11.56%	12.46%

Hospital Name	Total Admissions	Total Readmissions	Readmissions Out of Maryland	Readmission Rate	MD Readmission Rate	**Out-of-State (OOS) Ratio**	Case-Mix Adjusted Readmission Rate	Case-Mix Adjusted Rate with OOS Adjustment
A	**B**	**C**	**D**	**E=C/B**	**F**	**G=E/F**	**H**	**I=G*H**
210055 - LAUREL REGIONAL	1066	225	16	21.11%	19.61%	1.08	11.66%	12.55%
210030 - CHESTERTOWN	928	147	10	15.84%	14.76%	1.07	13.72%	14.72%
210005 - FREDERICK MEMORIAL	5530	706	41	12.77%	12.03%	1.06	9.56%	10.15%
210057 - SHADY GROVE	4900	627	34	12.80%	12.10%	1.06	9.79%	10.35%
210019 - PENINSULA REGIONAL	7776	1068	57	13.73%	13.00%	1.06	10.43%	11.02%
210018 - MONTGOMERY GENERAL	2902	396	18	13.65%	13.03%	1.05	10.64%	11.15%
210023 - ANNE ARUNDEL	9195	1127	49	12.26%	11.72%	1.05	10.91%	11.41%
210001 - MERITUS	6236	1137	43	18.23%	17.54%	1.04	11.01%	11.44%
210058 - REHAB & ORTHO	299	27	1	9.03%	8.70%	1.04	6.91%	7.18%
210065 - HOLY CROSS GERMANTOWN	1090	165	6	15.14%	14.59%	1.04	10.50%	10.90%
210002 - UNIVERSITY OF MARYLAND	6561	1247	45	19.01%	18.32%	1.04	12.65%	13.12%
210010 - DORCHESTER	181	35	0	19.34%	19.34%	1.00	11.84%	11.84%
210037 - EASTON	4614	648	22	14.04%	13.57%	1.04	10.81%	11.19%
210006 - HARFORD	1688	311	10	18.42%	17.83%	1.03	11.95%	12.35%
210033 - CARROLL COUNTY	4373	627	20	14.34%	13.88%	1.03	11.11%	11.48%
210029 - HOPKINS BAYVIEW MED CTR	6556	1431	34	21.83%	21.31%	1.02	14.09%	14.43%
210008 - MERCY	3864	472	11	12.22%	11.93%	1.02	11.90%	12.18%
210034 - HARBOR	2114	344	8	16.27%	15.89%	1.02	12.14%	12.43%
210024 - UNION MEMORIAL	4450	591	13	13.28%	12.99%	1.02	12.21%	12.48%
210063 - UM ST. JOSEPH	6225	736	14	11.82%	11.60%	1.02	10.57%	10.77%

Hospital Name	Total Admissions	Total Readmissions	Readmissions Out of Maryland	Readmission Rate	MD Readmission Rate	**Out-of-State (OOS) Ratio**	Case-Mix Adjusted Readmission Rate	Case-Mix Adjusted Rate with OOS Adjustment
A	**B**	**C**	**D**	**E=C/B**	**F**	**G=E/F**	**H**	**I=G*H**
210040 - NORTHWEST	4616	789	15	17.09%	16.77%	1.02	12.16%	12.40%
210044 - G.B.M.C.	4613	540	10	11.71%	11.49%	1.02	10.42%	10.62%
210048 - HOWARD COUNTY	5533	870	13	15.72%	15.49%	1.02	11.13%	11.30%
210043 - BALTIMORE WASHINGTON MEDICAL CENTER	7422	1276	18	17.19%	16.95%	1.01	12.26%	12.44%
210013 - BON SECOURS	667	147	2	22.04%	21.74%	1.01	14.70%	14.90%
210015 - FRANKLIN SQUARE	7136	1299	15	18.20%	17.99%	1.01	12.33%	12.47%
210038 - UMMC MIDTOWN	1265	303	3	23.95%	23.72%	1.01	14.74%	14.89%
210049 - UPPER CHESAPEAKE HEALTH	5335	757	7	14.19%	14.06%	1.01	10.81%	10.91%
210012 - SINAI	6080	1002	8	16.48%	16.35%	1.01	11.86%	11.96%
210056 - GOOD SAMARITAN	4209	702	5	16.68%	16.56%	1.01	11.80%	11.88%
210011 - ST. AGNES	4956	763	5	15.40%	15.29%	1.01	11.95%	12.03%
210045 - MCCREADY	181	35	0	19.34%	19.34%	1.00	12.77%	12.77%
210064 - LEVINDALE	169	30	0	17.75%	17.75%	1.00	9.13%	9.13%

APPENDIX VI. MATHEMATICA POLICY RESEARCH – RRIP MODELING

MATHEMATICA
Policy Research

RRIP RY2019

Preliminary Target Projections and Scales

Performance Measurement Work Group Meeting

March 15, 2017

Matthew J. Sweeney

Outline

- Update projections with new CMS data
- Calculate Maryland Medicare FFS improvement target
- Convert Medicare FFS target to all-payer improvement target
- Draft Improvement and Attainment Scales
  – Cumulative vs. One-Year Improvement

Projecting National Medicare FFS Rate (1)

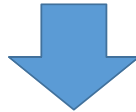
- Use historical data to estimate national FFS rate in 2017 and 2018

- Test a variety of methods
  - Average annual % change from CY 2013 to CY 2016
  - Annual % change from CY 2015 to CY 2016
  - 12-month moving average
  - 24-month moving average

- To create conservative targets:
  - Choose method late that predicts lowest national rates
  - Simulate more aggressive changes in national rates

Projecting National Medicare FFS Rate (2)

Year	National Medicare FFS Rate
2013	15.38%
2014	15.49%
2015	15.42%
2016 (estimated)*	15.27%



	Projections of National Rate	Basis for Estimate
2017	15.23%	Average Annual Change 2013 - 2016
	15.12%	Annual Change from 2015 to 2016
	15.26%	12-month moving average
	15.33%	24-month moving average

	Projections of National Rate	Basis for Estimate
2018	15.20%	Average Annual Change 2013 - 2016
	14.97%	Annual Change from 2015 to 2016
	15.25%	12-month moving average
	15.31%	24-month moving average

* 2016 rate estimated by taking the percent change in the national rate from the November 2014-October 2015 time period to the November 2015 -October 2016 time period and applying it to the 2015 rate.

Setting Maryland FFS Target

A. Maryland FFS Rate versus National Rate

Year	National Medicare FFS Rate	Maryland Medicare FFS Rate	DIfference
2013	15.38%	16.60%	1.22%
2014	15.49%	16.46%	0.97%
2015	15.42%	15.95%	0.53%
2016 (estimated)	15.27%	15.69%	0.42%

B. Percent Reduction Required in Maryland FFS Rate, Based on Various Projections of 2018 National Ra

	0.98 Percent Decrease (based on 2015-2016 trend)	1.0 Percent Decrease	1.5 Percent Decrease
2018 Target Rate	14.97%	14.97%	14.81%
Cummulative Reduction Required	-4.59%	-4.61%	-5.57%
Annual Reduction Required	-2.32%	-2.33%	-2.82%

Setting All-Payer Target

A. Maryland All-Payer Rate Trend

Year	National Medicare FFS Rate	Maryland Medicare FFS Rate	All-Payer Rate
2013	15.38%	16.60%	12.93%
2014	15.49%	16.46%	12.43%
2015	15.42%	15.95%	12.02%
2016 (estimated)	15.27%	15.69%	11.57%

B. Construct Conversion Factor

MD Medicare FFS Change CY13-CY16	-5.5%
All Payer Readmission Change CY13- CY16	-10.5%
Conversion Factor (use ratio of changes)	**0.523**

C. Develop One-Year Improvement Target

	0.98 Percent Decrease (based on 2015-2016 trend)	1.0 Percent Decrease	1.5 Percent Decrease
Medicare FFS Reduction Target (2016 to 2017)	-2.32%	-2.33%	-2.82%
All-Payer Target (2016 to 2017)	**-4.44%**	**-4.45%**	**-5.40%**

Setting Draft Scales - Overview

- Retain 1 percent maximum reward and 2 percent maximum penalty
- No major changes to attainment scale setting
- Discuss options for improvement scale setting

Attainment Scale

- Adjust CY 2016 risk-adjusted rates by:
  - Out of state readmission factor (from CMS data)
  - Expected improvement factor (2 percent)
- Benchmark for any reward:
  - Top 25th percentile of adjusted 2016 rates
- Benchmark for 1 percent max reward:
  - Top 10th percentile of adjusted 2016 rates
- Extrapolate remainder of incentive points (linear function)

Draft Attainment Scale

All Payer Readmission Rate CY17	Over/Under Target	RRIP % Inpatient Revenue Payment Adjustment
LOWER		1.0%
9.92%	-0.9%	1.0%
10.38%	-0.5%	0.5%
10.83%	0.0%	0.0%
11.29%	0.5%	-0.5%
11.74%	0.9%	-1.0%
12.20%	1.4%	-1.5%
12.65%	1.8%	-2.0%
Higher		-2.0%

Improvement Scale - Options

- **Re-baseline improvement to CY 2016**
  - **One year improvement target**
    - Preliminary target = - 5%
  - **Resets program to reflect most recent experience**
  - **All hospitals face same improvement target, regardless of improvement to date**

- **Use modified version of cumulative approach**
  - **Statewide target = actual statewide improvement + one year improvement target**
    - Actual statewide improvement 2013 - 2016= - 11%
    - One year required improvement 2016 – 2017 (prelim) = - 5%
    - Cumulative improvement target (2013 – 2017) = - 16%

Improvement Scale – Re-baselined Option

- Use 2015 to 2016 rates to simulate distribution of one-year improvement rates
- Benchmark for maximum 1 percent reward: 10th percentile of improvement distribution
- Benchmark for any reward: one-year target improvement of 5 percent
- Extrapolate remainder of incentive points (linear function)

Draft Improvement Scale – One Year

All Payer Readmission Rate Change CY16-CY17	Over/Under Target	RRIP % Inpatient Revenue Payment Adjustment
LOWER		1.0%
-13.00%	-8.0%	1.0%
-9.00%	-4.0%	0.5%
-5.00%	0.0%	0.0%
-1.00%	4.0%	-0.5%
3.00%	8.0%	-1.0%
7.00%	12.0%	-1.5%
11.00%	16.0%	-2.0%
Higher		-2.0%

Improvement Scale – Modified Cumulative

- Statewide target = actual statewide improvement + one year improvement target
  - Actual statewide improvement 2013 - 2016= - 11%
  - One year required improvement 2016 – 2017 (prelim) = - 5%
  - Cumulative improvement target (2013 – 2017) = - 16%
- Calculate linear function using actual 2013 to 2016 improvement
  - Benchmark for any reward: - 9.5%
  - Benchmark for maximum 1 percent reward: top 10th percentile
- Reset linear function using 2017 target of – 16%
  - Retains same slope of linear function from RY 2018 program

Draft Improvement Scale – Modified Cumulative

All Payer Readmission Rate Change CY13-CY17	Over/Under Target	RRIP % Inpatient Revenue Payment Adjustment
LOWER		1.0%
-26.50%	-10.5%	1.0%
-21.25%	-5.3%	0.5%
-16.00%	0.0%	0.0%
-10.75%	5.3%	-0.5%
-5.50%	10.5%	-1.0%
-0.25%	15.8%	-1.5%
5.00%	21.0%	-2.0%
Higher		-2.0%

Next Steps

- Explore alternative options for improvement incentives

- Examine data discrepancies
  - Differences between HSCRC FFS rate and CMS FFS rate
  - Assess impact on setting improvement targets

Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2018

April 12, 2017

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document contains the draft staff recommendations for providing continued financial support of the Maryland Patient Safety Center. Comments on this draft may be submitted via hard copy or email to Katie Wunderlich at Katie.wunderlich@maryland.gov by COB April 26, 2017.

Table of Contents

List of Abreviations 1
Introduction 2
Background 3
Assessment 3
  Strategic Priorities and Partnerships 3
  Maryland Patient Safety Center Activities, Accomplishments, and Outcomes 4
  FY 2018 Quality and Safety Initiatives 5
  FY 2018 Projected Budget 6
  MPSC Return on Investment 8
Recommendations 8
Appendix I. MPSC Report to HSCRC on FY 2017 Results and FY 2018 Program Plan and Budget Request

LIST OF ABREVIATIONS

Delmarva	Delmarva Foundation for Medical Care
DHMH	Department of Health and Mental Hygiene
FY	Fiscal Year
HQI	Hospital Quality Initiative
HSCRC	Health Services Cost Review Commission
MHA	Maryland Hospital Association
MHCC	Maryland Health Care Commission
MPSC	Maryland Patient Safety Center
NAS	Neonatal Abstinence Syndrome
RFP	Request for Proposals

INTRODUCTION

In 2004, the Maryland Health Services Cost Review Commission (HSCRC or Commission) adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates. The initial recommendations funded 50 percent of the reasonable budgeted costs of the MPSC. The HSCRC collaborates on MPSC projects as appropriate, and receives an annual briefing and documentation on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on staff experience and the annual information provided by the MPSC, staff evaluates the reasonableness of the budget items presented and makes continued financial support recommendations to the Commission.

Over the past 12 years, the HSCRC increased the rates of eight Maryland hospitals by the following amounts in order to provide funding to cover the costs of the MPSC. Funds are transferred on a biannual basis (by October 31 and March 31 of each year).

- FY 2005 - $762,500
- FY 2006 - $963,100
- FY 2007 - $1,134,980
- FY 2008 - $1,134,110
- FY 2009 - $1,927,927
- FY 2010 - $1,636,325
- FY 2011 - $1,544,594
- FY 2012 - $1,314,433
- FY 2013 - $1,225,637
- FY 2014 - $1,200,000
- FY 2015 - $1,080,000
- FY 2016 - $972,000
- FY 2017 - $874,800

In February 2017, the HSCRC received the MPSC program plan update for fiscal year (FYs) 2017 and 2018 (see Appendix I). The MPSC is requesting a total of $831,060 in funding support from the HSCRC for FY 2018, a 5 percent decrease over the previous year.

BACKGROUND

The 2001 General Assembly passed the Patients' Safety Act of 2001,[1] charging the Maryland Health Care Commission (MHCC)—in consultation with the Maryland Department of Health and Mental Hygiene (DHMH)—with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland, including a system of reporting such incidences. The MHCC subsequently recommended the establishment of the MPSC to improve patient safety in Maryland.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.[2]

The MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) through the State's Request for Proposals (RFP) procurement process to establish and operate the MPSC in 2004, with an agreement that the two organizations would collaborate in their efforts. MHA and Delmarva jointly operated the MPSC from 2004 to 2009. The MPSC was then reorganized as an independent entity and was re-designated by the MHCC as the state's patient safety center starting in 2010 for two additional five-year periods. The MPSC's current designation extends through December 2019.

ASSESSMENT

Strategic Priorities and Partnerships

The MPSC's vision is to be a center of patient safety innovation, convening health care providers to accelerate understanding of, and implement evidence-based solutions for preventing avoidable harm. Its mission is to make healthcare in Maryland the safest in the nation.

The MPSC's goals are to:

- Eliminate preventable harm for every patient, with every touch, every time
- Develop a shared culture of safety among patient care providers
- Be a model for safety innovation in other states

To accomplish its vision, mission, and goals, the MPSC established and continues to build new strategic partnerships with an array of key private and public organizations. The organizations represent a broad array of interests and expertise, including

---

[1] Chapter 318, 2001 Md. Laws.
[2] MD. CODE. ANN., Health-Gen. § 1-401(b)(14);(d)(1).

policymakers and providers across the continuum of healthcare quality, safety, and learning and education. See Appendix I for more details on the MPSC's priorities and partnerships.

Maryland Patient Safety Center Activities, Accomplishments, and Outcomes

Below are highlights of the MPSC's key accomplishments for FY 2017 (more fully outlined in Appendix I):

MPSC Members and Partnerships

- The MPSC included 43 dues-paying member hospitals
- The Mid-Atlantic Patient Safety Organization, a component of the MPSC, included 37 facilities
- The MPSC included 12 strategic partners

Initiatives

- Began marketing of the Caring for the Caregiver program, with strong interest from hospitals in Maryland, New York, South Carolina, and California
- Initiated the Primary Cesarean-Section program in July 2016
- Initiated the Neonatal Abstinence Syndrome program in October 2016, which includes 31 birthing hospitals
- Recruited 18 hospitals, 3 long-term care facilities, and 5 ambulatory surgical centers to the Clean Collaborative initiative
- Continued the decrease in sepsis mortality through the Sepsis Collaborative program
- Served as a consultant to the Hospital Quality Institute (HQI) on the long-term care sepsis collaborative, which includes 35 Maryland long-term care facilities

Educational Programs and Conferences

- Customized educational programs for MPSC members driven by changing needs of members and the healthcare industry
- Expanded the reach of the MPSC and increased participation levels of member hospitals through educational opportunities
- Convened the Annual Maryland Patient Safety Center Conference, which is the MPSC's signature event providing awareness, education, and information regarding best practice solutions
- Convened the Annual Medication Safety Conference, which concentrates on the prevention of medication errors

FY 2018 Quality and Safety Initiatives

The MPSC has a number of ongoing multi-year quality and safety initiatives, as well as new initiatives that will commence in FY 2018. Ongoing initiatives include the following:

- **Improving Sepsis Survival Collaborative:** This initiative is designed to reduce sepsis mortality at Maryland hospitals by working with participating hospitals to share successes, challenges, experiences, and ideas through facilitated meetings, calls, and webinars. The goal of the collaborative is to reduce sepsis mortality by ten percent at participating hospitals, with an ultimate goal of sharing best practices to reduce sepsis mortality statewide. Currently, 21 hospitals participate in two cohorts (Cohort I contains 10 hospitals and Cohort II contains 11 hospitals). The hospitals self-report monthly mortality data for patients with severe sepsis and septic shock and submit a quarterly status report. The MPSC is also in discussion with HSCRC staff about an expanded multi-year sepsis initiative.
- **Clean Collaborative:** In order to reduce healthcare associated infections, the MPSC contracted with CleanHealth Environmental to lead the Clean Collaborative initiative. Teams from hospitals, long-term care facilities, and ambulatory surgical centers are provided with both in-person and virtual opportunities to convene panels of experts to share best management practices for cleaning and disinfecting facility-wide surface areas, as well as opportunities to facilitate team collaboration. Currently, 18 hospitals, 3 long-term care facilities, and 5 ambulatory surgical centers participate in the collaborative. All participating healthcare facilities utilize clean validation technology at no cost. Participating facilities submit monthly sample results from targeted patient care and public areas. The MPSC's Clean Collaborative began in March 2016 and will end data collection in April 2017. The goal of the collaborative is to reduce the number of relative light units sampled in each facility by ten percent in order to reduce the number of healthcare associated infections in the State.
- **Neonatal Abstinence Syndrome (NAS) Collaborative:** The MPSC is facilitating a collaborative to improve the care of infants with NAS, which contributes to a significant amount of health care costs and resources and is increasing with the opioid epidemic. Participants include 31 birthing hospitals in Maryland, as well as the Mt. Washington Pediatric Hospital. The NAS Collaborative aims to standardize care for infants with NAS by providing hospitals with evidence-based best practices and education. Ultimately, the goal of the collaborative is to reduce length of stay, 30-day readmissions, and transfers to higher levels of care for infants with NAS. This collaborative began in October 2016 and will finish by September 2018.
- **Reducing Primary Cesareans and Supporting Intended Vaginal Births:** Since July 2016, the MPSC has partnered with the Alliance for Innovation in Maternal Health (AIM) to conduct the Reducing Primary Cesareans and Supporting

Intended Vaginal Births initiative. The initiative uses emerging scientific, clinical, and patient safety advances to reduce primary (first time) cesarean rates in singleton, vertex term deliveries by ten percent.

- **Adverse Event Reporting:** Initiated in July 2016, the Adverse Event Reporting initiative is a Patient Safety Organization that identifies trending patient safety issues, such as medication errors, at select Maryland hospitals. Data collected on adverse events help to determine future programming and educational needs for Maryland hospitals.

Three new initiatives will commence in FY 2018:

- **Medication Reconciliation**: A multi-disciplinary study group will explore potential opportunities to improve the process of medication reconciliation to improve patient safety.
- **Diagnostic Errors**: A study group will explore the role that the MPSC could take in the emerging work on diagnostic errors.
- **Opioid Misuse**: In response to the statewide opioid addiction epidemic, the MPSC has partnered with MHA and MedChi to propose a patient-centered statewide public awareness campaign aimed at educating consumers on opioid use. Topics will include reasonable pain management expectations, the pros and cons of opioid use, opioid prescription storage and disposal, and important questions to ask when being prescribed an opioid medication.

FY 2018 Projected Budget

The MPSC continued to work with its partners to secure program-specific funding for FY 2018 and estimated the amounts it will secure for FY 2018 in the proposed budget outlined in Figure 1 below. Cash contributions from MHA, Delmarva, individual hospitals, and long-term care facilities are not included in the FY 2018 revenue amount. Hospitals and long-term care facilities will now pay annual member dues. The MPSC is also working on bolstering other revenue streams, such as the training and licensing of the Caring for the Caregiver program. The ultimate goal is diversifying the MPSC's revenue sources to create stability in fiscal planning.

Figure 1. Proposed MPSC Revenue and Expenses

	FY 2017			FY 2018		
Revenue			**Budget**			**Budget**
Cash Contributions from MHA/Delmarva			100,000			-
Cash Contributions from Hospitals			30,000			-
Cash Contributions for Long-term Care			25,000			-
HSCRC Funding			874,800			831,060
Membership Dues			350,000			375,000
Education Session Revenue			14,000			9,000
Conference Registrations-Annual MedSafe Conference			2,000			2,000
Conference Registrations-Annual Patient Safety Conference			75,000			30,000
Sponsorships			140,000			170,000
Program Sales			60,000			60,000
Patient Safety Certification Revenue			85,000			25,000
DHMH Grant			200,000			200,000
Other Grants/Contributions			50,000			50,000
Total Revenue			**2,005,800**			**1,752,060**
	FY 2017			**FY 2018**		
Expenses	**MPSC**	**Consultants**	**Total**	**MPSC**	**Consultants**	**Total**
Administration	581,750		581,750	578,826		578,826
Outpatient Dialysis (previously committed)	-		-	-		-
Programs			-			-
Education Sessions		69,000	69,000		65,000	65,000
Annual Patient Safety Conference		370,500	370,500		289,500	289,500
MEDSAFE Conference		33,250	33,250		19,250	19,250
Caring for HC	93,400	50,000	143,400	65,890	40,000	105,890
Patient/Family Centered Care	-	-	-	-	-	-
Safety Initiatives-Perinatal/Neonatal	206,850	-	206,850	218,156	-	218,156
Safety Initiatives-Hand Hygiene	-	-	-	-	-	-
Safety Initiatives-Safe from Falls	-	-	-	-	-	-
Safety Initiatives-Adverse Event Reporting	25,100	40,000	65,100	41,700	-	41,700
Patient Safety Certification	132,300	15,000	147,300	46,500	-	46,500
Sepsis	38,200	47,150	85,350	44,960	15,000	59,960
Clean Environment	61,300	97,900	159,200	49,600	58,000	107,600
Patient Family Bundle	22,700	-	22,700	-	-	-
Med Rec	19,500	-	19,500	33,600	-	33,600
Surgical	19,500	-	19,500	-	-	-
Diagnosis Errors	19,500	-	19,500	39,400	5,000	44,400
Opioid Misuse	-	-	-	118,000	5,000	123,000
Total Expenses	**1,220,100**	**722,800**	**1,942,900**	**1,236,632**	**496,750**	**1,733,382**
Net Income (Loss)			**62,900**			**18,678**

MPSC Return on Investment

As noted in the last several Commission recommendations, the All-Payer Model provides funding for the MPSC with the expectation that there will be both short- and long-term reductions in Maryland healthcare costs, particularly related to such outcomes as reduced mortality rates, lengths of stay, patient acuity, and malpractice insurance costs. The MPSC must continue to collect data on its programs in order to show quantifiable improvements in patient safety and outcomes.

Based on the data generated and reported by the MPSC (e.g., a 13 percent reduction in sepsis mortality in cohort II and a 20 percent reduction in sepsis mortality at all Maryland hospitals), HSCRC staff believes that the MPSC programs align with the goals of the All-Payer Model and have the opportunity to assist hospitals with meeting key metrics. For instance, the Sepsis Collaborative and the Clean Collaborative align with the Commission's goals of improved quality and outcomes through reduced healthcare acquired conditions. Additionally, the MPSC continues efforts to maintain other sources of revenue, such as conference registration fees and membership dues, demonstrating that the MPSC is of value to their provider customer base.

RECOMMENDATIONS

Quality and safety improvements are the primary drivers of the State's All-Payer Model in order to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings. For these reasons, it is important to continue to support hospitals in identifying best practices to improve patient quality and outcomes.

In light of the information presented above, HSCRC staff provides the following draft recommendations for the MPSC funding support policy for FY 2018:

1. The HSCRC should provide funding support for the MPSC in FY 2018 through an increase in hospital rates by the amount of $831,060, a $43,740 (5 percent) reduction from FY 2017.
2. The MPSC should to continue to aggressively pursue other sources of revenue, including other provider groups that benefit from MPSC programs, in order to help support the MPSC in the future and maintain reasonable cash reserves.
3. Going forward, the HSCRC should decrease the amount of support by 10 percent per year, or a greater amount contingent upon:
    a. How well the MPSC initiatives align with a broader statewide plan and activities for patient safety
    b. Whether new MPSC revenues offset HSCRC funding support.

Maryland Patient Safety Center FY 2017 Update and FY 2018 Program Plan

Presented to the

Health Services Cost Review Commission

February 2017

Maryland Patient Safety Center Board of Directors

- **James R. Rost, MD**, Medical Director, NICU and Medical Director of Patient Safety, Adventist Healthcare Shady Grove Medical Center
- **Gerald Abrams**, Director
  Abrams, Foster, Nole & Williams, PA
- **Kelly Corbi**, Chief Operating Officer
  Northwest Hospital
- **Carmela Coyle**, President & CEO
  Maryland Hospital Association
- **Joseph DeMattos, Jr.**, **MA**, President
  Health Facilities Association of Maryland
- **Barbara Epke**, Vice President
  LifeBridge Health, Inc. & Sinai Hospital of Baltimore
- **E. Robert Feroli, Jr**., **PharmD, FASHP, FSMSO**
  Johns Hopkins Hospital, Department of Pharmacy
- **Eugene Friedman**, Former Corporate Counsel
  1st Mariner Bank
- **Paul Fronstin, Ph.D.,** Director
  Center for Research and Health Benefits Innovation
  Employee Benefit Research Institute
- **David Horrocks**, President
  CRISP
- **Andrea Hyatt**, President
  Maryland Ambulatory Surgery Association
- **Sen. Katherine Klausmeier**
  Maryland State Senate, District 8
- **Robert Imhoff**, President & CEO
  Maryland Patient Safety Center
- **Lawrence Linder, MD, FACEP, FAAEM**
  President and CEO
  University of Maryland Community Medical Group
- **David Mayer, MD**
  Corporate Vice President of Quality and Safety
  MedStar Health
- **Sherry Perkins**, **PhD, RN**, COO and CNO
  Dimensions Health
- **Steve Ports**, Former Principal Deputy Director
  Health Services Cost Review Commission
- **Del. Sheree Sample-Hughes**
  Maryland General Assembly, District 37 A
- **Barbara Tachovsky,** Former President, Main Line Hospitals, Paoli, PA.
- **Kathleen White**, **PhD, RN, NEA-BC, FAAN**,
  Associate Professor
  The Johns Hopkins University School of Nursing
- **Michael Yochelson**, **MD, MBA, FACHE**
  Vice President, Medical Affairs and Chief Medical Officer
  MedStar National Rehabilitation Network

MPSC Members FY 2017

- Adventist Health Care, including:
    - Adventist Behavioral Health
    - Shady Grove Medical Center
    - Washington Adventist Hospital
- Adventist Rehabilitation Hospital
- Anne Arundel Medical Center
- Atlantic General Hospital
- Bon Secours Baltimore Health System
- Calvert Memorial Hospital
- Carroll Hospital Center
- Doctors Community Hospital
- Fort Washington Medical Center
- Frederick Regional Health System
- Garrett County Memorial Hospital
- Greater Baltimore Medical Center
- Holy Cross Hospital
- Johns Hopkins Howard County General Hospital
- Johns Hopkins Suburban Hospital
- Kennedy Krieger Institute
- Laurel Regional Hospital (Dimensions Health)
- Levindale Hebrew Geriatric Center & Hospital
- McCready Health
- MedStar Franklin Square Medical Center
- MedStar Good Samaritan Hospital
- MedStar Southern Maryland Hospital Center
- MedStar St. Mary's Hospital
- MedStar Union Memorial Hospital
- Mercy Medical Center
- Northwest Hospital
- Prince George's Hospital Center (Dimensions Health)
- Sheppard Pratt Health System
- Sinai Hospital of Baltimore
- Union Hospital of Cecil County
- UMD Baltimore Washington Medical Center
- UMD Charles Regional Medical Center
- UMD Medical Center
- UMD Medical Center Midtown Campus
- UMD Rehabilitation & Orthopaedic Institute
- UMD Shore Medical Center Dorchester
- UMD Shore Medical Center Easton
- UMD Shore Medical Center Chestertown
- UMD St. Joseph Medical Center
- UMD Upper Chesapeake Health
- Western Maryland Health System

MARYLAND Patient Safety CENTER

Mid Atlantic PSO Members FY 2017

- Anne Arundel Medical Center
- Atlantic General Hospital
- Bon Secours Hospital
- Calvert Memorial Hospital
- Carroll Hospital Center
- Doctors Community Hospital
- Frostburg Nursing and Rehabilitation Center
- Ft. Washington Medical Center
- Garrett County Memorial Hospital
- Greater Baltimore Medical Center
- Kennedy Krieger Institute
- Laurel Regional Hospital
- Levindale Hebrew Geriatric Center
- MedStar St. Mary's Hospital
- MedStar Union Memorial Hospital
- Mercy Medical Center
- Meritus Medical Center
- Mt. Washington Pediatric Hospital
- Northwest Hospital
- Prince George's Hospital Center
- SagePoint Senior Living Services
- Sheppard Pratt Health System
- Sinai Hospital
- Union Hospital of Cecil County
- UMD Baltimore Washington Medical Center
- UMD Charles Regional Medical Center
- UMD Harford Memorial Hospital
- UMD Medical Center
- UMD Medical Center Midtown Campus
- UMD Rehabilitation and Orthopaedic Institute
- UMD Shore Health at Chestertown
- UMD Shore Health at Dorchester
- UMD Shore Health at Easton
- UMD Rehabilitation and Orthopedic Institute
- UMD St. Joseph's Medical Center
- UMD Upper Chesapeake Medical Center
- Washington Adventist Hospital
- Western Maryland Health System

MARYLAND Patient Safety CENTER

Strategic Partners

- **NextPlane -** National vendor of adverse event reporting services
- **HQI** – Maryland QIO
- **Vermont Oxford Network -** Voluntary collaboration of healthcare professionals working together as an interdisciplinary community to change the landscape of neonatal care
- **American College of Obstetricians and Gynecologists -** National organization promoting maternal and infant health
- **Health Facilities Association of Maryland -** A leader and advocate for Maryland's long-term care provider community
- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association
- **Maryland Hospital Association** - The advocate for Maryland's hospitals, health systems, communities, and patients before legislative and regulatory bodies
- **MedChi -** Statewide professional association for licensed physicians
- **CRISP -** Regional health information exchange (HIE) serving Maryland and the District of Columbia
- **Society to Improve Diagnosis in Medicine -** National non-profit that catalyzes and leads change to improve diagnosis and eliminate harm
- **Maryland Ambulatory Surgical Association -** The state membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to the patients they serve
- **Johns Hopkins School of Medicine / The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine

FY17 Highlights

- Began marketing of Caring for the Caregiver with strong interest from hospitals in Maryland, NY, SC, and CA.
- Member hospitals totaled 43
- Mid-Atlantic PSO members include 37 facilities
- Commenced Primary Caesarean-Section initiative July 2016
- Commenced Neonatal Abstinence Syndrome initiative October 2016
- Clean Collaborative includes 18 hospitals, 3 LTC and 5 ASCs
- Sepsis Collaborative continues to show reductions in sepsis mortality
- Serve as a consultant to HQI on their LTC Sepsis collaborative (35 MD LTCs)

FY18 Initiatives: Education Programs

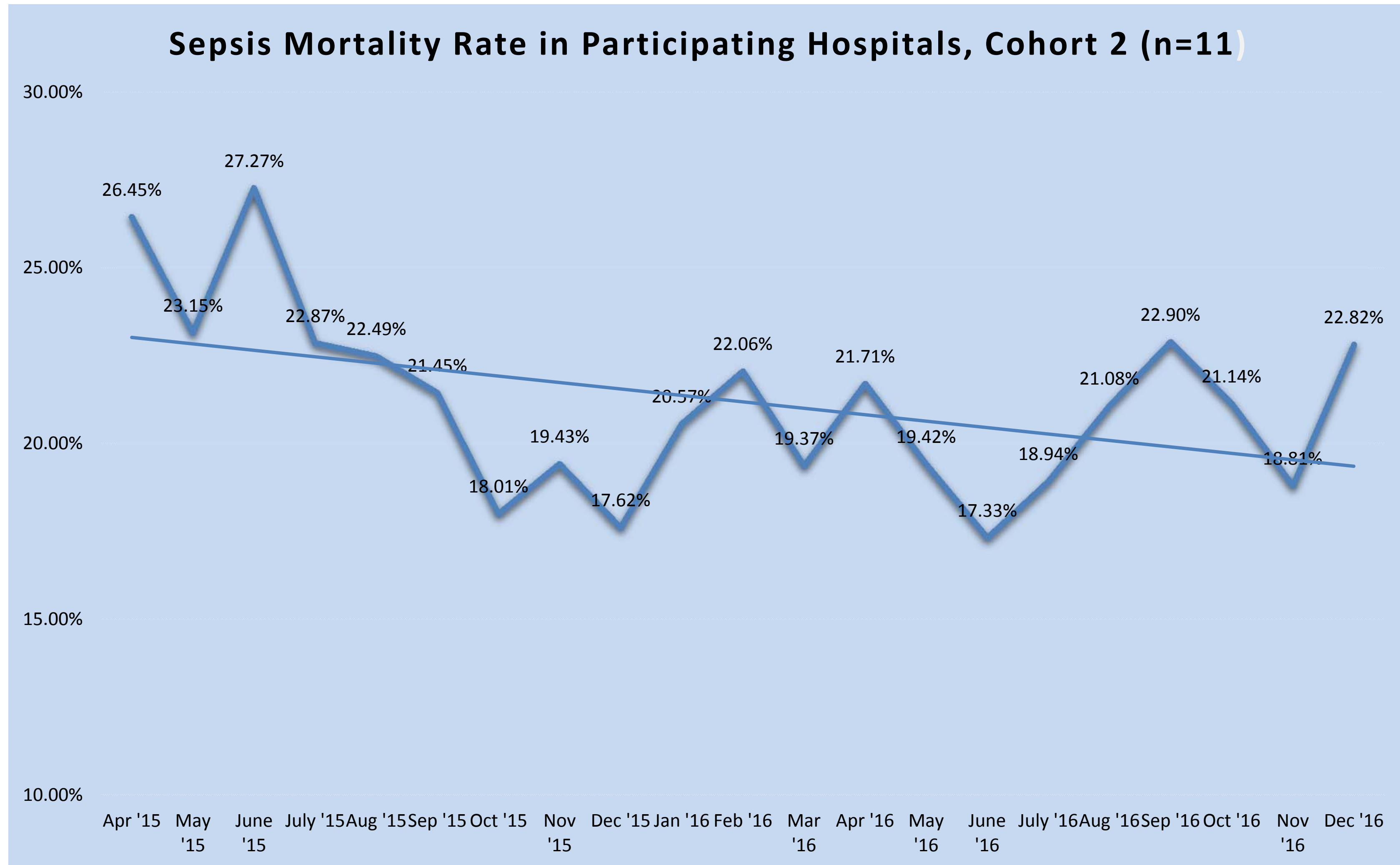
- Educational programming according to needs of members & marketplace.
- Objectives:
  - Educate providers regarding pertinent patient safety/medication safety related issues
  - Expand participant reach of the Center
  - Increase participation levels
  - Increase revenue generation
  - Establish Center as recognized educational resource

MARYLAND Patient Safety CENTER

FY18 Initiatives: Conferences

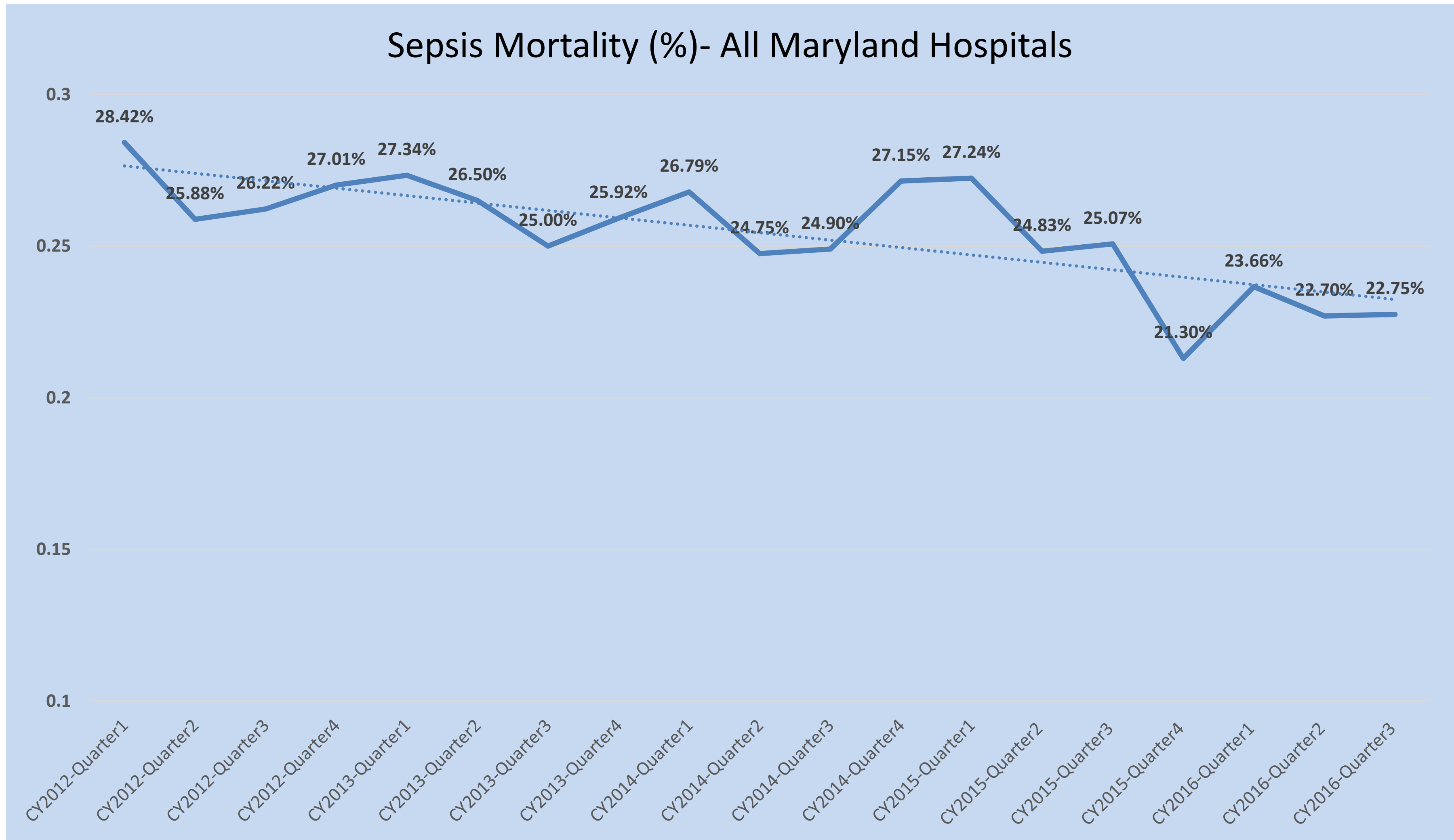
- The Annual Maryland Patient Safety Center Conference is the Center's signature event; providing awareness, education and the exchange of best practice solutions to a broad-based audience that goes well beyond the Center's usual participants. The annual Medication Safety Conference has become a premier event for the Center concentrating on the prevention of medication errors with an emphasis on processes and technology.
- Objectives:
  - Educate providers regarding pertinent patient safety / medication safety related issues
  - Expand participant reach of the Center
  - Increase participation levels
  - Increase revenue generation
  - Establish Center as recognized educational resource

Improving Sepsis Survival



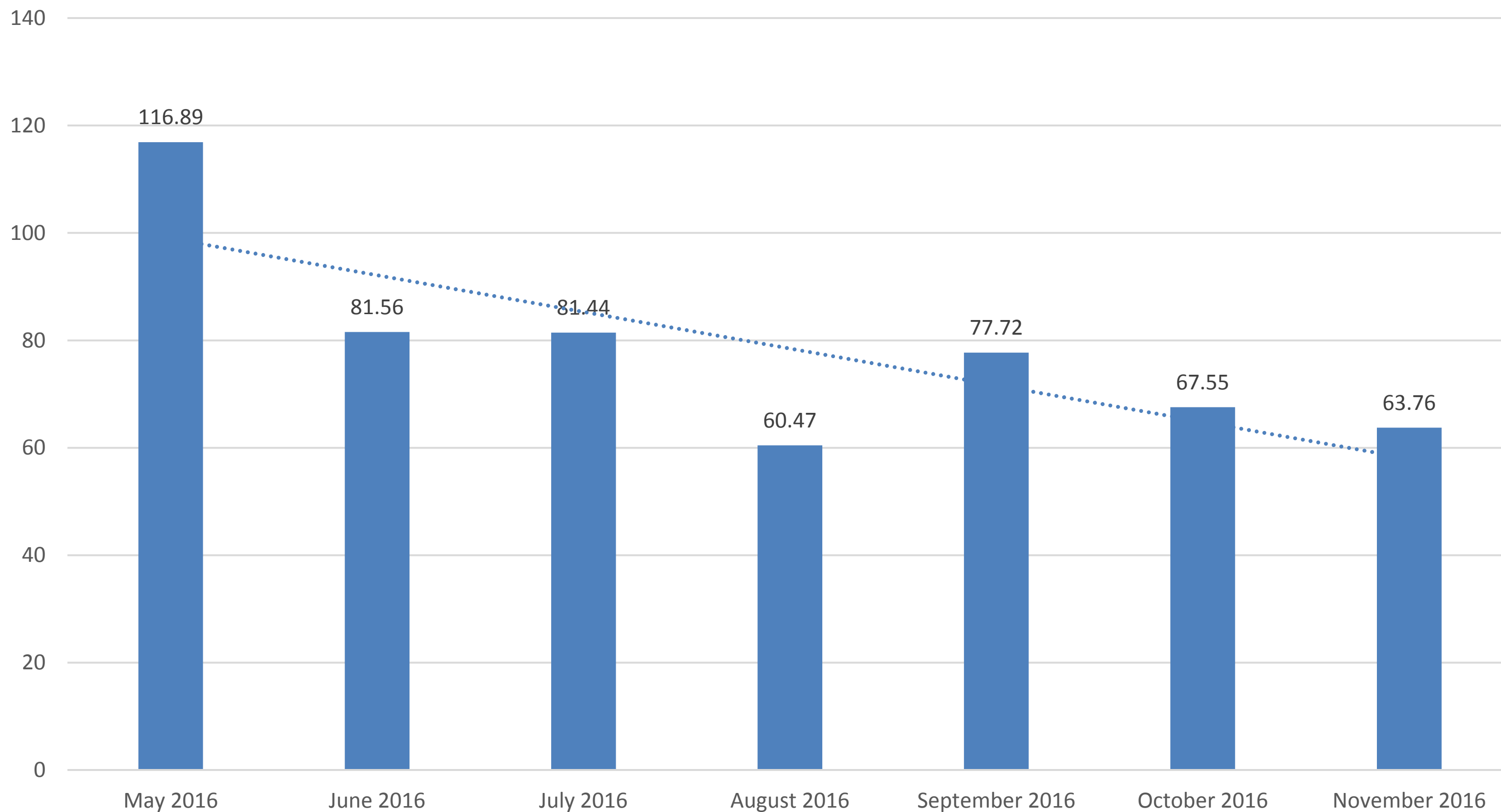
MARYLAND Patient Safety CENTER

Improving Sepsis Survival



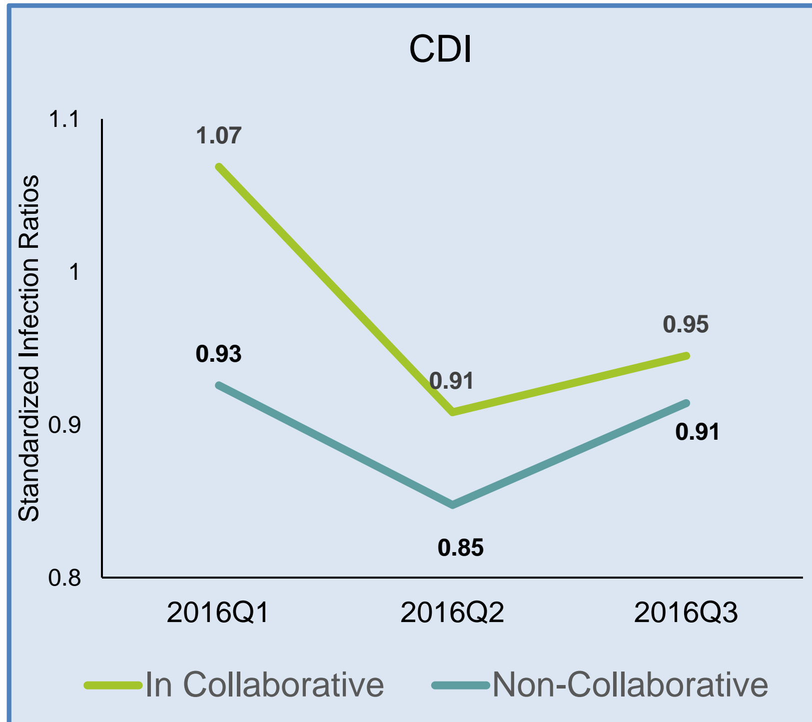
MARYLAND Patient Safety CENTER

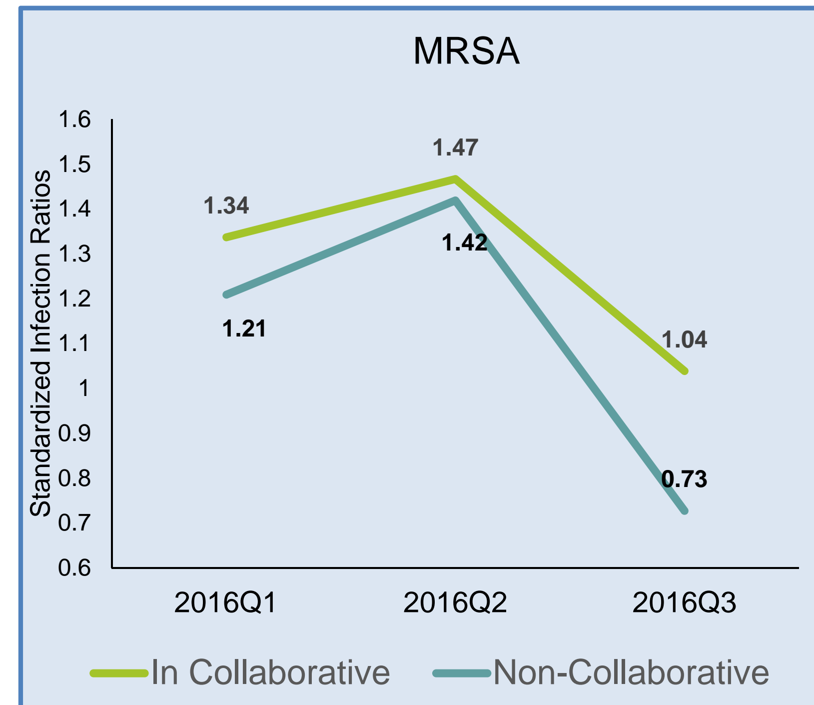
Clean Collaborative



MARYLAND Patient Safety CENTER

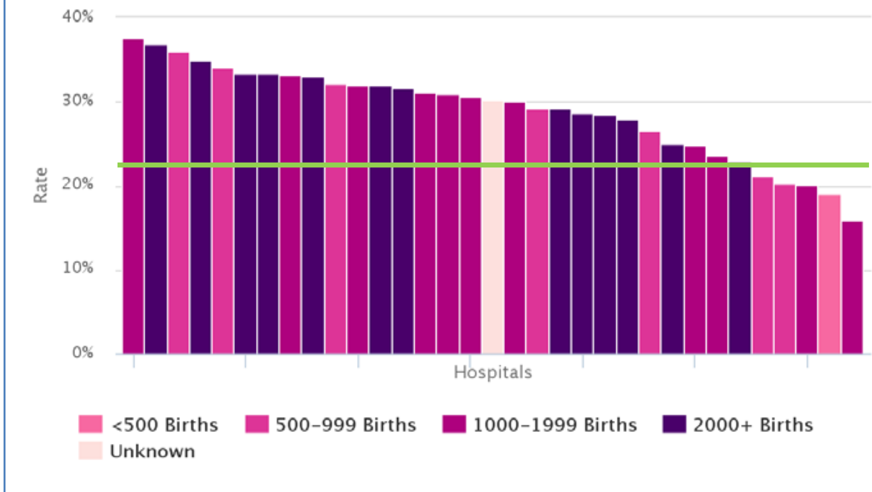
Clean Collaborative



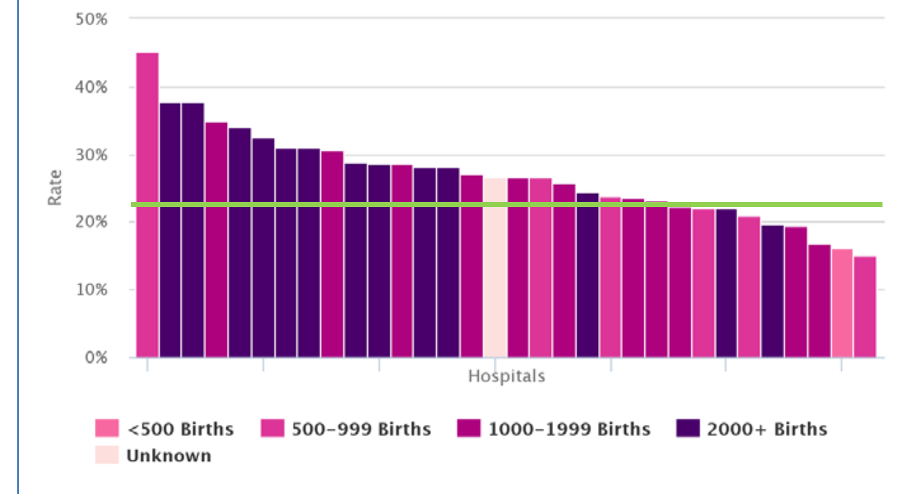


MARYLAND Patient Safety CENTER

Reducing Primary C-Sections



Healthy People 2020 C-section Goal for all sections 23.9%



MARYLAND Patient Safety CENTER

Neonatal Abstinence Syndrome

- Commenced October 2016
- 31 of 32 Maryland birthing hospitals participating
- Baseline data – January, February, March 2016
  - 139 cases of medically treated NAS cases in 31 hospitals
  - 22.3% transferred out to either higher level of care or for longer term treatment
  - Median NICU stay 11 days
  - Median hospital stay 19 days
- Readmission data not yet reported

MARYLAND Patient Safety CENTER

Adverse Event Reporting

- Initiated July 2016
- Six facilities reporting
- 10,207 adverse events entered as of 2.9.17 (includes historical) going back to date of the facility PSO contract
- Largest category - Medication Events
- Data will determine future programming
- Trending data to be posted on MPSC website

FY18 Initiatives: Safety Initiatives

- **Perinatal/Neonatal Quality Collaborative**
  - Reduce rate of primary C-sections in nulliparous, singleton, term vertex (NTSV) (readmissions, LOS)
  - Standardizing care and treatment of neonatal abstinence syndrome (readmissions, LOS, transfers to higher levels of care)
- **Stopping Sepsis (LTC)**
  - Partnering with HQI to improve early identification and treatment of sepsis in the post acute setting (readmissions, LOS)
- **Clean Collaborative**
  - Reduce incidence of HAI's through improved practices related to surface contamination (PPC's, LOS, HAI)
- **Errors in Diagnosis**
  - A three phase, multi-year initiative that will first determine the scope of the problem, develop actions and implement those procedures and protocols (LOS, readmissions, utilization)
- **Opioid Misuse**
  - State-wide public awareness initiative in partnership with MedChi and MHA aimed at educating the public about several components related to opioid misuse (utilization, LOS)
- **Medication Reconciliation**
  - Development of a tool/checklist in order to obtain the best possible medication history (readmissions, LOS)
- **Adverse Event Reporting**
  - Data submissions from hospitals in order to determine trending patient safety issues

MARYLAND Patient Safety CENTER

Strategic Direction

- Improve culture of patient safety
- Expand provider involvement
- Maintain patient / family centered care focus
- Supporting provider efforts with regard to Waiver requirements and initiatives
- Continued coordination with statewide healthcare priorities:
  - HSCRC
  - OHQC
  - MHCC
  - DHMH

GBR Infrastructure Investment – FY 2016

4/12/2016

Overview

- Intent of these monies is to accelerate the development of **care coordination**.
- Commission required that hospitals report on all new population health investments for FY 2016.
- Reports were reviewed by a committee of **HSCRC** and **DHMH** staff.

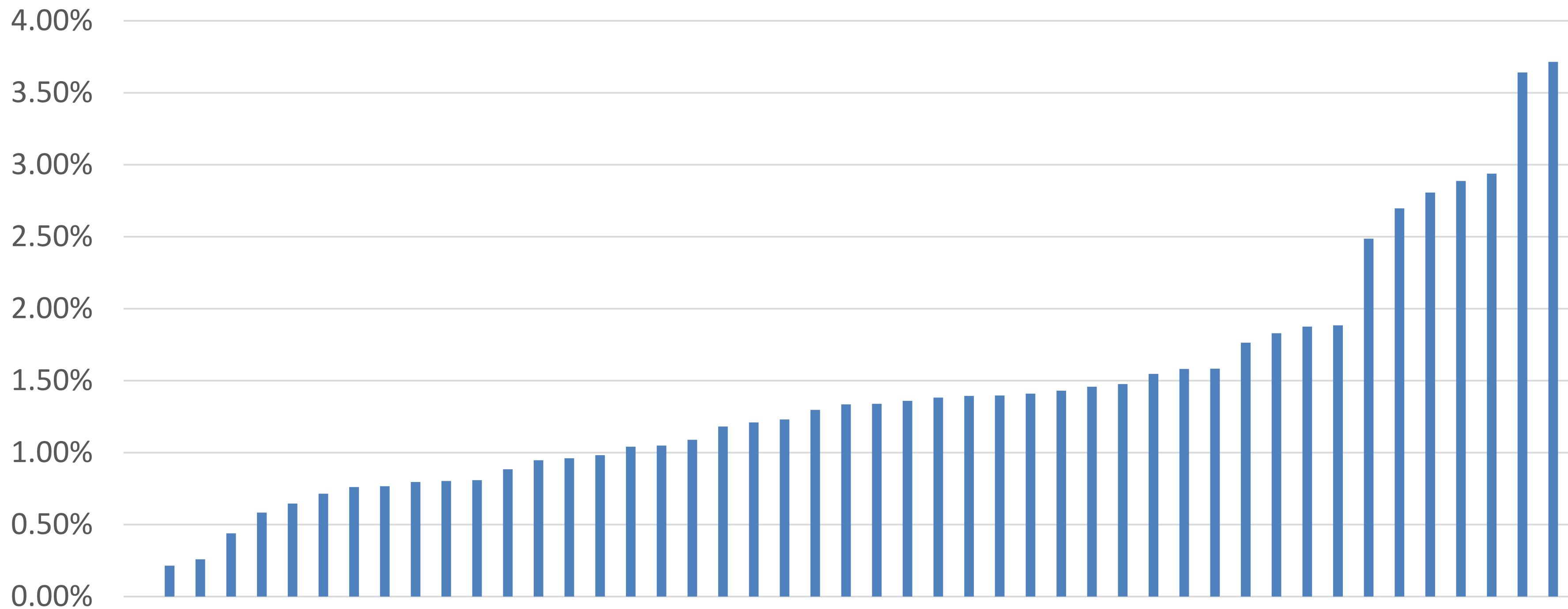
GBR Infrastructure Reports – A Snapshot

- To date, HSCRC has received reports from 46 hospitals, detailing over 700 infrastructure investments made during FY 2016.
- The individual infrastructure investment reports are posted on the Commission's website at the following link: http://www.hscrc.maryland.gov/plans.cfm
- Infrastructure Spending:
  - Total Reported: total reported minus grant or other funds
  - Moderate Estimate: partially discounts investments that represented ongoing hospital expenditures or unclear investments; wholly discounts non-germane investments

Investment Spending	All Hospitals	GBR Only*
Total Investments	$199 M	$163 M
Moderate Estimate	$144 M	$120 M

*For comparison purposes, the estimated amount of money put into GBR hospital rates in FY 2016 was approximately $146 M

% of FY 2016 GBR Invested in Infrastructure

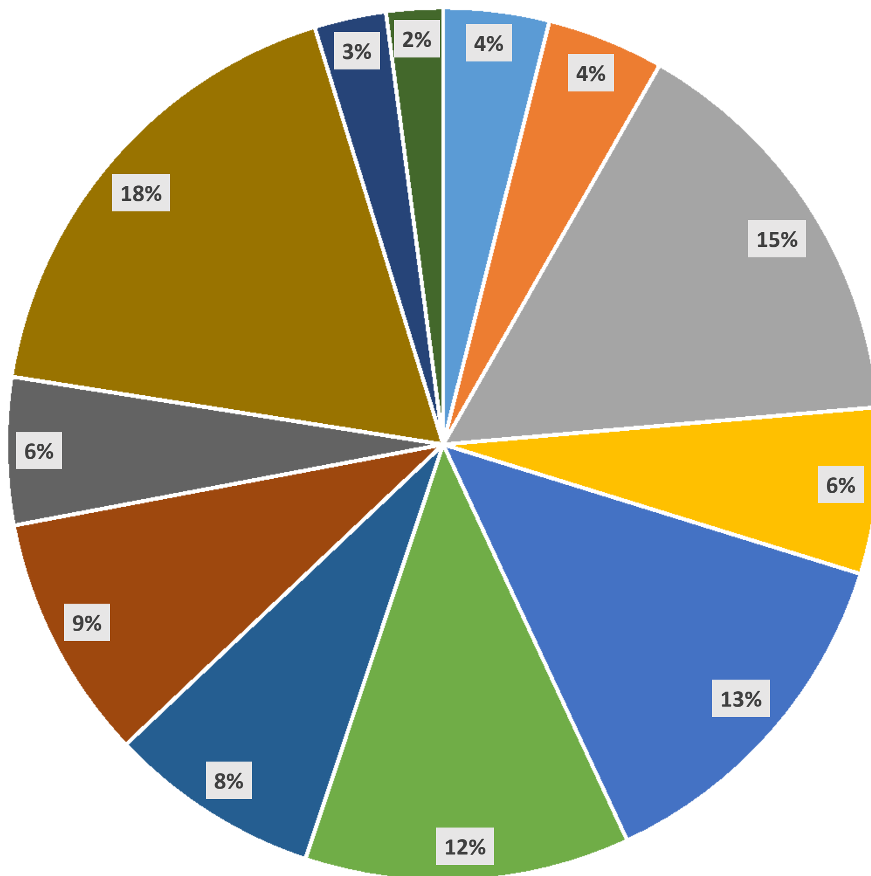


FY 2016 Reporting Template - Categories

- HSCRC worked with stakeholders to update the reporting template to include standardized investment categories with agreed-upon definitions.

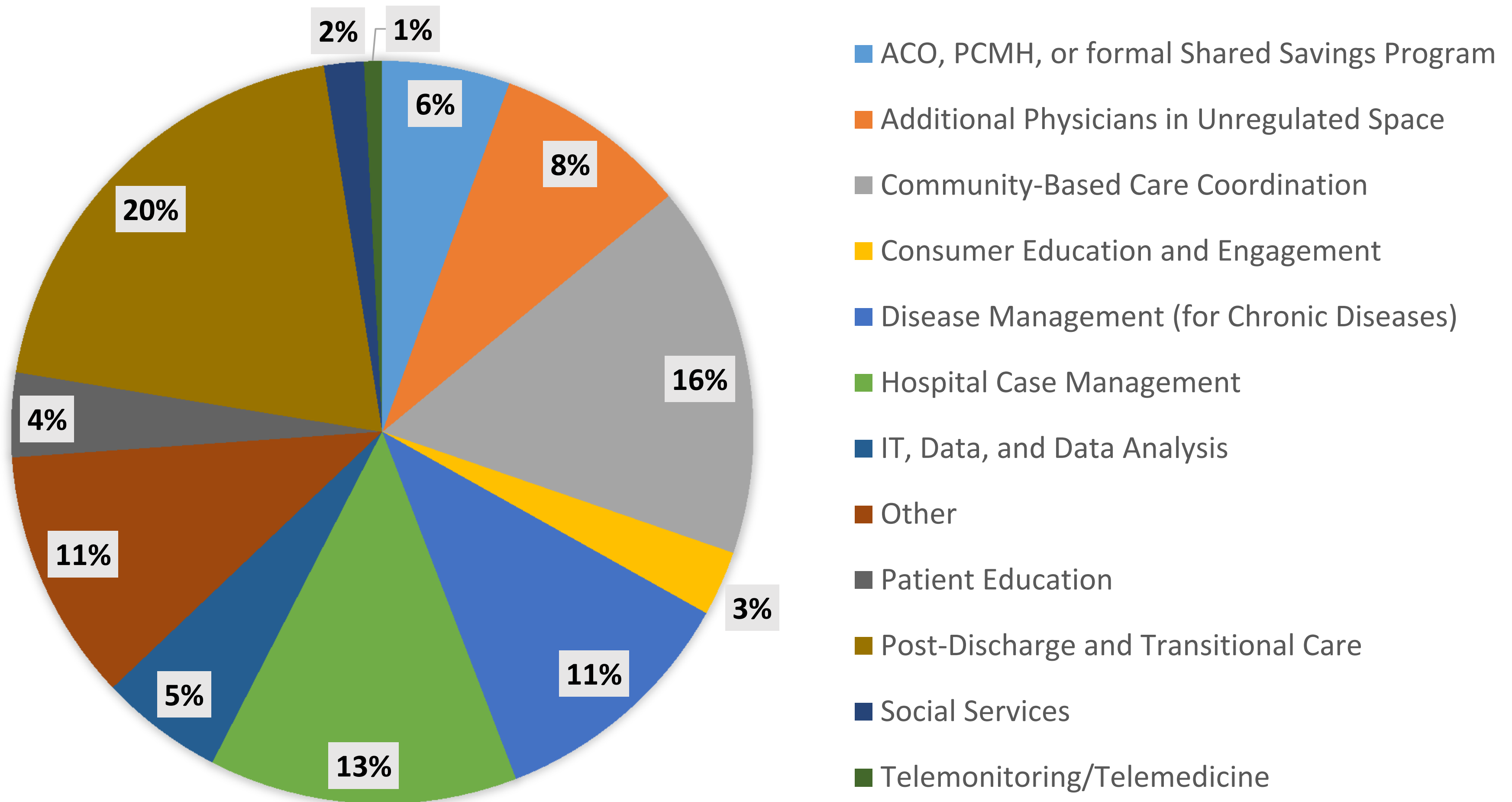
- Categories refined with definitions
  1. ACO, PCMH, or formal Shared Savings Program
  2. Additional Physicians in Unregulated Space
  3. **Community-based Care Coordination**
  4. Consumer Education and Engagement
  5. **Disease Management (for Chronic Diseases)**
  6. Hospital Case Management
  7. IT, Data, and Data Analysis
  8. Patient Education
  9. **Post-Discharge and Transitional Care**
  10. Social Services
  11. Telemonitoring/Telemedicine
  12. Other

Count of Investments by Category (N=715)

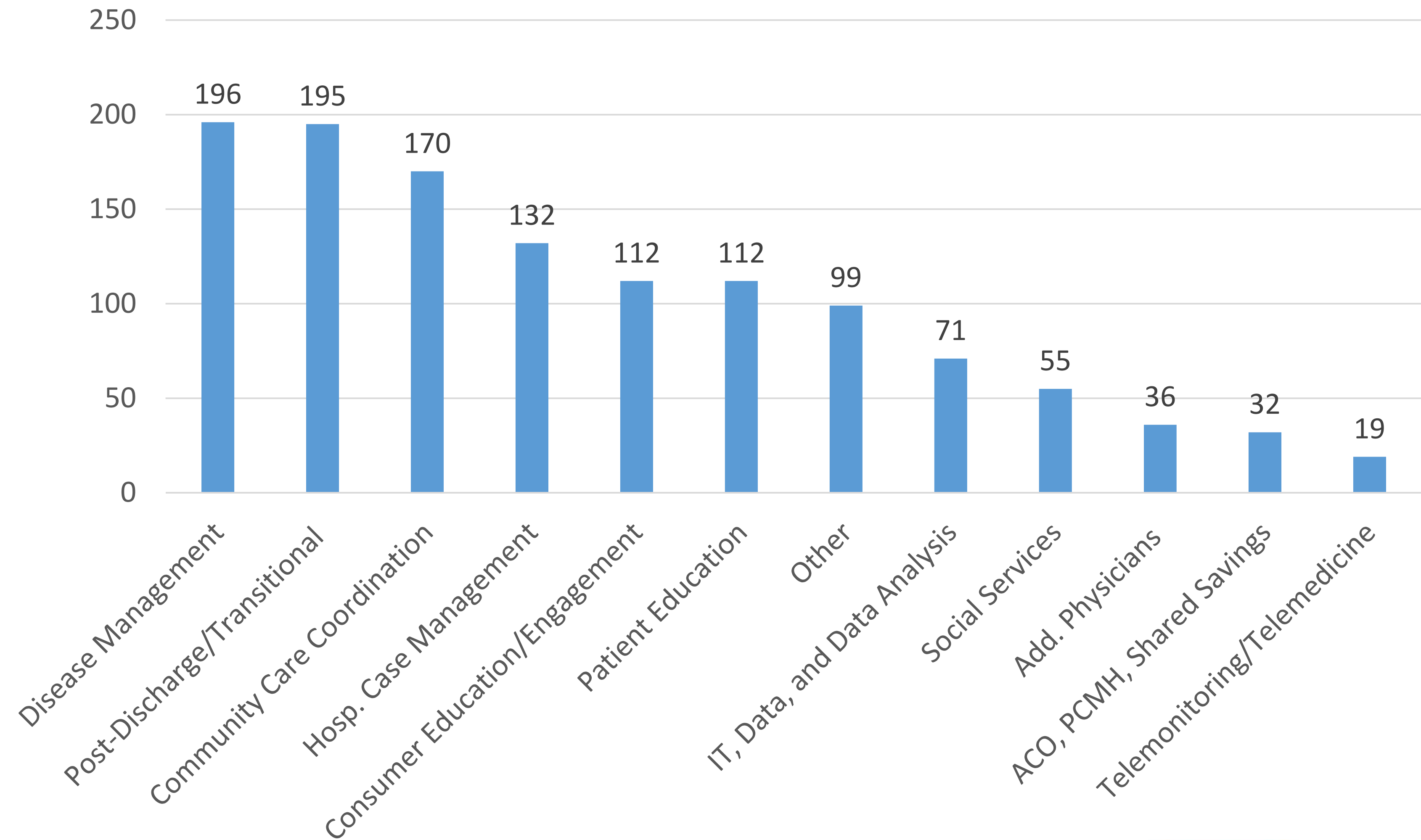


- ACO, PCMH, or formal Shared Savings Program
- Additional Physicians in Unregulated Space
- Community-Based Care Coordination
- Consumer Education and Engagement
- Disease Management (for Chronic Diseases)
- Hospital Case Management
- IT, Data, and Data Analysis
- Other
- Patient Education
- Post-Discharge and Transitional Care
- Social Services
- Telemonitoring/Telemedicine

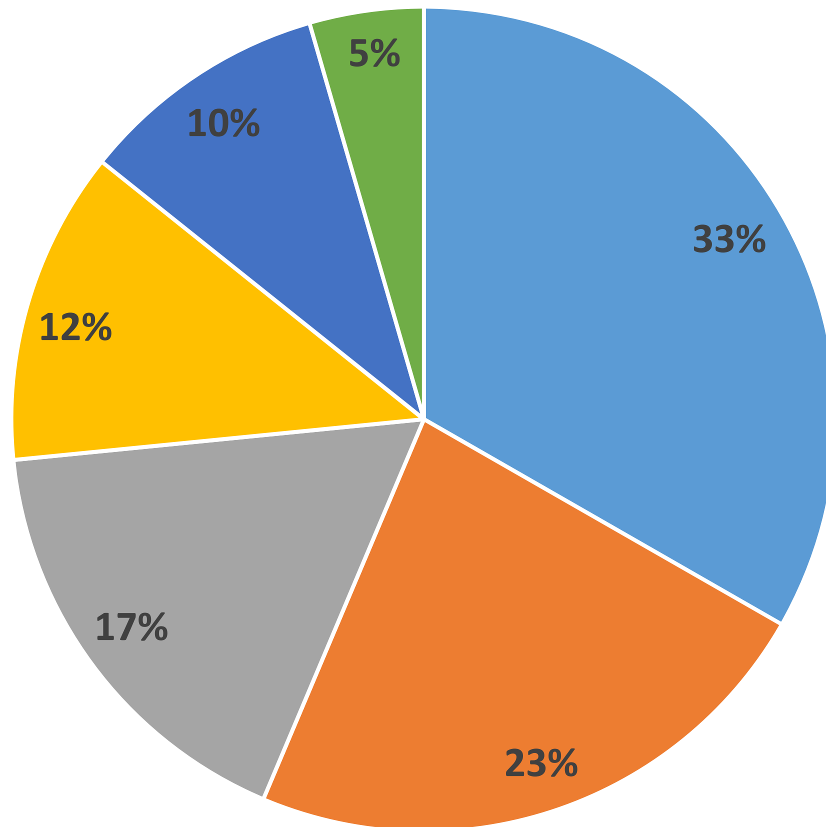
Investments $ by Category



Categories (Hospitals could add up to 3)

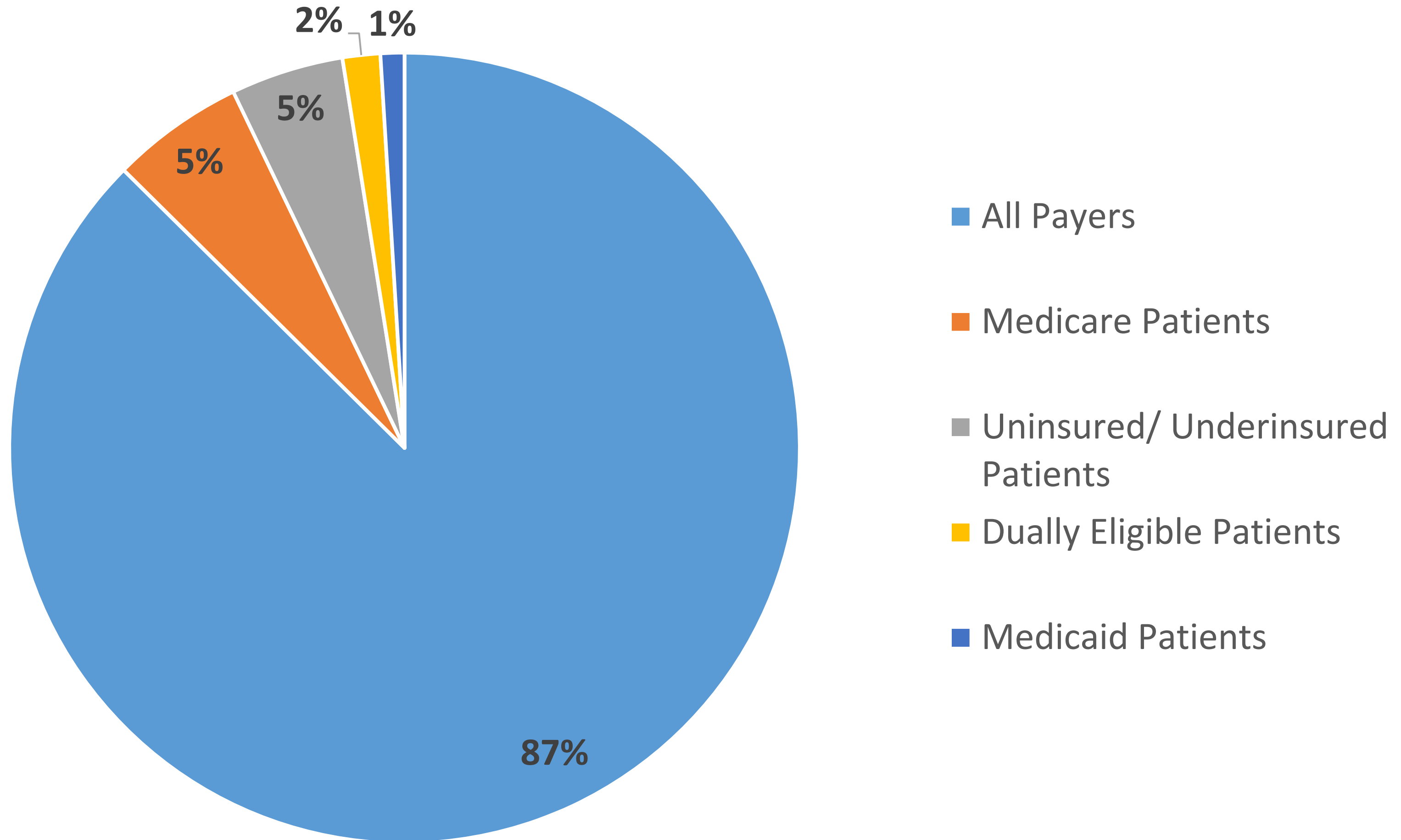


Target Populations



- Complex, High Needs Patients
- Hospitalized Patients
- Other Target Patient Population
- "Rising Risk", Patients with Chronic Conditions
- ED Patients
- Patients in Post-Acute Setting or Long-term Care

Target Payer



HSCRC
Health Services Cost Review Commission

FTEs working on GBR Infrastructure

- ~2,300 FTEs across all hospitals
- Representing ~2.7% of total FTEs (via Financial Reports)

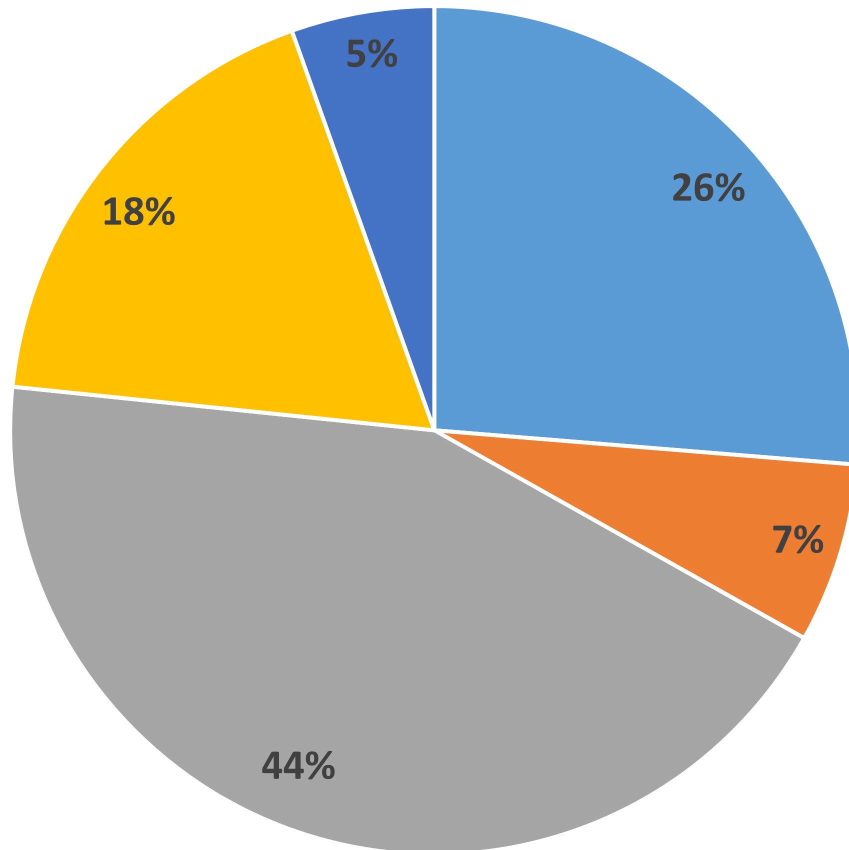
FTE Type	Numbers of FTEs	% of Total FTE
IT Staff	33.6	1.43%
Data Analyst	51.9	2.21%
Physician - Specialty Care	62.3	2.65%
Community Health Worker	66.7	2.83%
Hospital Management	97.4	4.14%
Physician - Primary Care	108.9	4.63%
Advanced Practitioner (Nurse Practitioner, Physician Assistant, etc)	121.9	5.18%
Physician - Hospital-based	122.3	5.19%
Social Worker	158.3	6.73%
RN	656.2	27.87%
Other	874.7	37.15%
Total FTEs	2354.3	

Partner Analysis

Clinical Partners (Most Relevant)	# of Investments	% of Investments
Owned by hospital/health system	285	39.86%
None	143	20.00%
Partially or wholly independent	110	15.38%
Other	83	11.61%
Long-term Care Facilities and Skilled Nursing Facilities	46	6.43%
Community-based Care Managers	32	4.48%
Retail Pharmacies	16	2.24%

Non-Clinical Partners (Most Relevant)	# of Investments	% of Investments
None	271	37.90%
CRISP	146	20.42%
Other	94	13.15%
Organizations that provide Social Services	74	10.35%
Local Health Departments	58	8.11%
Departments of Aging	29	4.06%
Faith-based Community Organizations	21	2.94%
Local Health Improvement Coalitions (LHICs)	15	2.10%
Schools	7	0.98%

Impact on TCOC



- Impact on non-hospital services is unclear at this time.
- Likely decrease non-hospital services.
- Likely increase non-hospital services.
- No impact on amount of non-hospital services likely.
- Did not Answer

Care Coordination and Focus Investments

- Care Coordination Investments represented:

	Care Coordination Investments	% of All GBR Investments
Total Care Coordination Investments Reported	$ 43,574,497	21.65%
Moderate Care Coordination Investments Reported	$ 38,713,848	26.05%
Total # of Care Coordination Investments	170	23.78%

- Focus Investments (Community-based Care Coordination; Disease Management; Post-Discharge and Transitional Care) represented:

	Care Coordination Investments	% of All GBR Investments
Total Focus Investments Reported	$ 94,983,210	47.18%
Moderate Focus Investments Reported	$ 80,099,662	53.89%
Total # of Focus Investments	332	46.43%

Process Metrics

- Each investment's process metric was evaluated on the following scale:
  - 0 – Did not provide a process metric
  - 1 – Provided a process metric
  - 2 – Process metric rationale is valid
  - 3 – Presented a goal without data
  - 4 – Presented data toward this goal
  - 5 – Is on track to meet this goal (or is progressing toward this goal)

Care Coordination

Scale #	% of Investments
0	15.96%
1	11.75%
2	8.43%
3	6.93%
4	8.13%
5	48.80%

All Investments

Scale #	% of Investments
0	20.56%
1	13.29%
2	11.47%
3	6.85%
4	8.81%
5	39.02%

Examples of Metrics

- PCP Appointments scheduled for High-Risk patients before discharge
- Number of patients receiving home or bedside delivery of prescriptions
- Reduce High-Utilizer Visits
- HbA1c levels in OP diabetics
- Reduction in Readmissions from SNFs
- Pre- and Post- Assessments of Patient Education Programs
- Monitoring of HEDIS measures for Hypertension and Diabetes
- % of Behavioral Health Social Worker Evaluations leading to a referral

FY 2017 GBR Infrastructure Reporting

- HSCRC is considering suspending the GBR investment reporting for FY 2017
  - Allows hospitals to focus on care redesign reporting this year
  - In future years GBR reporting and care redesign reporting can be streamlined
  - Evaluate strategic plans or other options

Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2016

April 12, 2017

Health Services Cost Review Commission

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

Table of Contents

Executive Summary i
Introduction 1
Contents of Report 3
Notes to the Financial and Statistical Data 6
Details of the Disclosure of Hospital Financial and Statistical Data: Acute Hospitals 7
Details of the Disclosure of Hospital Financial and Statistical Data: Specialty Hospitals 60
Exhibit I-A. Change in Uncompensated Care, Regulated Operations 62
Exhibit I-B. Change in Uncompensated Care, Regulated Operations 65
Exhibit II-A. Change in Total Operating Profit/Loss, Regulated and Unregulated Operations 68
Exhibit II-B. Change in Total Operating Profit/Loss, Regulated and Unregulated Operations 71
Exhibit III A. Excess Profit/Loss 74
Exhibit III B. Excess Profit/Loss 76

EXECUTIVE SUMMARY

The Maryland Health Services Cost Review Commission (HSCRC or Commission) has completed the annual hospital financial disclosure report for fiscal year (FY) 2016.

In FY 2016, Maryland concluded its second year under the new agreement with the federal Centers for Medicare & Medicaid Services (CMS) and began the third year. Under the new All-Payer Model, the State's focus shifted from controlling the charge per case for Medicare inpatient hospital stays to controlling per capita hospital revenue growth (including both inpatient and outpatient hospital costs) for all payers. The new Model will assess whether Maryland's hospital all-payer system is a successful model for achieving the triple aim of:

- Lower costs
- Better patient experience
- Improved health

Calendar year (CY) 2014 was the first year of the new Model. Since FY 2016 straddles the end of the second year under the new Model and the beginning of the third year, this report focuses on the second year of the new Model's financial and quality metric performance, as well as traditional measures of hospital financial health.

The following are a number of Maryland All-Payer Model Performance Year 2 results:

1. Gross all-payer per capita hospital revenues from services provided to Maryland residents grew by 2.31 percent, which was slower than the 4.02 percent per capita growth in the Maryland economy in CY 2015.
2. Over the performance period of the Model, the State must achieve aggregate savings of at least $330 million in the Medicare per beneficiary total hospital expenditures for Maryland resident Medicare fee-for-service (FFS) beneficiaries. For Performance Year 2 (CY 2015), the State achieved $135 million in Medicare savings. The cumulative savings for CY 2014 and CY 2015 are $251million.
3. Over the Model's performance period, the State must shift at least 80 percent of all regulated hospital revenue for Maryland residents into population-based payment arrangements. The State successfully shifted 96 percent of hospital revenue into population-based payments through hospital global budgets.
4. Over the Model's performance period, the State must reduce the aggregate Medicare 30-day readmission rate for Medicare FFS beneficiaries to be less than or equal to the national readmission rate. The gap in the readmission rate between Maryland and the nation decreased by 0.70 percent over the first two performance years.
5. Over the performance period of the Model, the State must achieve an aggregate 30 percent reduction for all payers in 65 potentially preventable complications (PPCs) as

part of Maryland's Hospital Acquired Conditions program. The State achieved a 34.1 percent reduction in PPCs in 2015 compared to 2014.

This report shows that for Maryland acute hospitals in FY 2016:

1. Profits on regulated activities increased in FY 2016, from $1.1 billion (or 8.39 percent of regulated net operating revenue) in FY 2015 to $1.2 billion (or 8.56 percent of regulated net operating revenue).
2. Profits on operations (which include profits and losses from regulated and unregulated day-to-day activities) decreased from $532 million (or 3.54 percent of total net operating revenue) in FY 2015 to $512 million in FY 2016 (or 3.29 percent of total net operating revenue).
3. Total excess profits (which include profits and losses from regulated and unregulated operating and non-operating activities) decreased substantially from $530 million in FY 2015 (or 3.52 percent of the total revenue) to $362 million in FY 2016 (or 2.33 percent of the total revenue).
4. Total regulated net patient revenue rose from $13.4 billion in FY 2015 to $13.9 billion in FY 2016, an increase of 3.74 percent.
5. In FY 2016, Maryland hospitals incurred $756 million in uncompensated care, amounting to approximately five cents of uncompensated care cost for every dollar of gross regulated patient revenue.
6. Gross regulated revenue from potentially avoidable utilization (PAU) readmissions fell from $1.153 billion in FY 2015 to $1.134 billion in FY 2016. The percentage of gross regulated revenue associated with total PAUs (readmission + avoidable admissions) declined from 11.30 percent in FY 2015 to 10.95 percent in FY 2016, a decrease of 3.1percent.
7. The case-mix adjusted PPC rate declined from 0.90 percent in FY 2015 to 0.73 percent in FY 2016, a decrease of 19.2 percent. These declines reflect improvement in the quality of care delivered in Maryland hospitals, where readmission rates declined faster than the national levels for Medicare, and the State achieved the 30 percent PPC reduction goal.
8. Total direct graduate medical education expenditures increased from $300 million in FY 2015 to $328 million in FY 2016, an increase of 9.42 percent.

The HSCRC, the country's pioneer hospital rate review agency, was established by the Maryland General Assembly in 1971 to regulate rates for all those who purchase hospital care. It is an independent Commission functioning within the Maryland Department of Health and Mental Hygiene. It consists of seven members who are appointed by the Governor. The HSCRC's rate review authority includes assuring the public that: (a) a hospital's total costs are reasonable; (b) a hospital's aggregate rates are reasonably related to its aggregate costs; and (c) rates are set equitably among all purchasers of care without undue discrimination or preference.

INTRODUCTION

Effective January 1, 2014, Maryland entered into a new hospital All-Payer Model with the Centers for Medicare & Medicaid Services (CMS). Under the new Model, the State's focus shifted from controlling the charge per case for a hospital stay to controlling the per capita total hospital cost growth. The new Model will assess whether Maryland's all-payer system for hospital payments—which is now accountable for the total hospital cost of care on a per capita basis—is a successful model for achieving the triple aim of:

- Lower costs
- Better patient experience
- Improved health

To facilitate these goals, every acute care hospital in Maryland agreed to a global budget. Global budgets remove the incentives for hospitals to grow volumes and instead focus hospitals on reducing potentially avoidable utilization (PAU), improving population health, and improving outcomes for patients. Maryland's performance under the All-Payer Model is measured by:

- Limiting the growth in gross per capita all-payer hospital revenues since calendar year (CY) 2013. Maryland has committed to holding the average annual growth rate over the five-year life of the Model to 3.58 percent.
- Generating savings for Medicare by holding the growth in Maryland Medicare fee-for-service (FFS) hospital payments per beneficiary below the national Medicare per beneficiary FFS growth rate. Maryland committed to saving Medicare $330 million over five years by keeping the State Medicare per beneficiary hospital growth rate below the national rate.
- Reducing potentially preventable complications (PPCs) by an aggregate of 30 percent over the five-year life of the Model.
- Reducing Maryland's Medicare readmission rate to the national average by the final year of the five-year Model.

This report focuses on hospital performance on the new Model's financial and quality metrics, as well as traditional measures of hospital financial health. This report includes hospital-level data on revenues associated with readmissions and other forms of PAU. Readmission and PAU charges provide a financial indicator of opportunity for improvement in selected areas if Maryland hospitals can successfully transform health care to the benefit of consumers. Reducing charges for PAU and readmissions will also provide hospital resources for additional investments in health care transformation. This report also illustrates performance on quality metrics, including the rates of case-mix adjusted readmissions (labeled risk-adjusted readmissions in the tables), and the case-mix adjusted PPC rate for each hospital.

Maryland's performance on many of the new Model metrics was favorable:

- All-payer per capita hospital revenues grew 2.31 percent, which is below the per capita growth of the Maryland economy in CY 2015 and well below the 3.58 percent annual growth gap contained in the waiver agreement.
- Medicare FFS hospital charges per Maryland Medicare beneficiary increased by 1.97 percent in FY 2016. National data for FY 2016 data indicate that Maryland costs grew slower than the nation.
- Charges for PAU readmissions decreased slightly from $1.153 billion in FY 2015 to $1.134 billion in FY 2016. Overall PAU charges decreased, from $1.810 billion in FY 2015 to $1.797 billion in FY 2016. As a percentage of gross regulated patient revenue, readmissions and PAU charges decreased between FY 2015 and FY 2016 by 4.0 percent and 3.1 percent respectively.
- Data on quality show that there was a reduction in the case-mix adjusted readmission and PPC rate. The case-mix adjusted readmission rate declined from 12.20 percent in FY 2015 to 11.72 percent in FY 2016, a decrease of 4.0 percent. The case-mix adjusted PPC rate declined from 0.90 percent in FY 2015 to 0.73 percent in FY 2016, a decrease of 19.2 percent. This decline reflects improvement in the quality of care delivered at Maryland hospitals. Since CY 2013, the PPC decrease has been greater than the CMS target of a 30 percent reduction by CY 2018.

Data on the collective financial performance of Maryland hospitals are summarized below.

- Gross regulated revenue growth. Gross patient revenue on regulated services increased 2.44 percent from $16.0 billion in FY 2015 to $16.4 billion in FY 2016.
- Net regulated patient revenue. Total regulated net patient revenue rose from $13.4 billion in FY 2015 to $13.9 billion in FY 2016, an increase of 3.74 percent.
- Profits on regulated activities. Profits on regulated activities increased in FY 2016, from $1.1 billion (8.39 percent of regulated net operating revenue) in FY 2015 to $1.2 billion (8.56 percent of regulated net operating revenue).
- Profits on operations. Profits on operations (which include profits and losses from regulated and unregulated day-to-day activities) increased from $532 million (or 3.54 percent of total net operating revenue) in FY 2015 to $512 million in FY 2016 (or 3.29 percent of total net operating revenue).
- Total excess profit. Total excess profits (which include profits and losses from regulated and unregulated operating and non-operating activities) decreased substantially from $530 million in FY 2015 (or 3.52 percent of the total revenue) to $362 million in FY 2016 (or 2.33 percent of the total revenue).
- Total Direct Graduate Medical Education Expenditures. Total direct graduate medical education expenditures increased from $300 million in FY 2016 to $328 million in FY 2016, an increase of 9.42 percent.[1]

---

[1] The HSCRC is working on expanding available information related to graduate medical education.

Maryland is the only state in which uncompensated care is financed by all payers—including Medicare and Medicaid—as the payment system builds the predicted cost of uncompensated care into the rates, and all payers pay the same rates for hospital care. Because the rates cover predicted uncompensated care amounts, hospitals have no reason to discourage patients who are likely to be without insurance. Thus, Maryland continues to be the only state in the nation that assures its citizens that they can receive care at any hospital, regardless of their ability to pay. As a result, there are no charity hospitals in Maryland; patients who are unable to pay are not transferred into hospitals of last resort. Because the actual uncompensated care is not reimbursed by the system, hospitals have incentives to pursue compensation from patients who generate uncompensated care expenses.

Additionally, the mark-up in Maryland hospitals—the difference between hospitals' costs and what hospitals ultimately charge patients—remained the lowest in the nation. The average mark-up for hospitals nationally is more than 3.6 times that of Maryland hospitals, according to the most recent data from the American Hospital Association. In the absence of rate setting, non-Maryland hospitals must artificially mark up their charges in order to cover shortfalls due to uncompensated care, discounts to large health plans, and low payments from Medicare and Medicaid.

CONTENTS OF REPORT

Under its mandate to publicly disclose information about the financial operations of all hospitals, the Maryland Health Services Cost Review Commission (HSCRC or Commission) has prepared this report of comparative financial information from the respective hospitals.

This report combines the financial data of hospitals with a June 30 fiscal year end with the hospitals with a December 31 year end of the previous year, e.g., June 30, 2016 and December 31, 2015, rather than combining together the financial data of hospitals whose fiscal years end in the same calendar year, e.g., June 30, 2015 and December 31, 2015, as was done in the past. All of the financial data in this report have been combined in this fashion. In FY 2014, the University of Maryland Upper Chesapeake Medical Center and the University of Maryland Harford Memorial Hospital changed from a December 31 fiscal year end to a June 30 fiscal year end. Because of this change in combining hospital data, the data for the six months from January 1, 2014 to June 30, 2014 for these hospitals were not included in this report. This report also marks the second annual filing submitted by Holy Cross Germantown Hospital, and includes nine months of data from its first year of operations, from October 1, 2014 to June 30, 2015.

The following categories were derived from the Annual Report of Revenue, Expenses, and Volumes (Annual Report) submitted to the HSCRC: Gross Patient Revenue, Net Patient Revenue, Other Operating Revenue, Net Operating Revenue, Percentage of Uncollectible Accounts, Total Operating Costs, Operating Profit/Loss, Non-Operating Revenue and Expense, and Excess Profit/Loss, as itemized in this report. The Annual Report is reconciled with the audited financial statements of the respective institutions.

This year's Disclosure Statement also includes the following three Exhibits:

- Exhibit I - Change in Uncompensated Care (Regulated Operations)

- Exhibit II - Change in Total Operating Profit/Loss (Regulated and Unregulated Operations)
- Exhibit III – Total Excess Profit/Loss (Operating and Non-Operating Activities)

The following explanations are submitted in order to facilitate the reader's understanding of this report:

Gross Patient Revenue refers to all regulated and unregulated patient care revenue and should be accounted for at established rates, regardless of whether the hospital expects to collect the full amount. Such revenues should also be reported on an accrual basis in the period during which the service is provided; other accounting methods, such as the discharge method, are not acceptable. For historical consistency, uncollectible accounts (bad debts) and charity care are included in gross patient revenue.

Net Patient Revenue means all regulated and unregulated patient care revenue realized by the hospital. Net patient revenue is arrived at by reducing gross patient revenue by contractual allowances, charity care, bad debts, and payer denials. Such revenues should be reported on an accrual basis in the period in which the service is provided.

Other Operating Revenue includes regulated and unregulated revenue associated with normal day-to-day operations from services other than health care provided to patients. These include sales and services to non-patients and revenue from miscellaneous sources, such as rental of hospital space, sales of cafeteria meals, gift shop sales, research, and Medicare Part B physician services. Such revenue is common in the regular operations of a hospital, but should be accounted for separately from regulated patient revenue.

Net Operating Revenue is the total of net patient revenue and other operating revenue.

Uncompensated Care is composed of charity and bad debts. This is the percentage difference between billings at established rates and the amount collected from charity patients and patients who pay less than their total bill, if at all. For historical consistency, uncollectible accounts are treated as a reduction in revenue.

Total Operating Expenses equal the costs of HSCRC-regulated and unregulated inpatient and outpatient care, plus costs associated with Other Operating Revenue. Operating expenses are presented in this report in accordance with generally accepted accounting principles with the exception of bad debts. For historical consistency, bad debts are treated as a reduction in gross patient revenue.

Operating Profit/Loss is the profit or loss from ordinary, normal recurring regulated and unregulated operations of the entity during the period. Operating Profit/Loss also includes restricted donations for specific operating purposes if such funds were expended for the purpose intended by the donor during the fiscal year being reported upon.

Non-Operating Profit/Loss includes investment income, extraordinary gains, and other non-operating gains and losses.

Excess Profit/Loss represents the bottom line figure from the Audited Financial Statement of the institution. It is the total of the Operating Profit/Loss and Non-Operating Profit/Loss. (Provisions for income tax are excluded from the calculation of profit or loss for proprietary hospitals.)

PAU is the general classification of hospital care that is unplanned and can be prevented through improved care, care coordination, and effective community-based care. The HSCRC intends to continue to refine the measurement of PAU and thus the current PAU numbers differ from previous disclosure reports. Currently, the following measures are included as PAU cost measures:

- 30-day, all-cause, all-hospital inpatient readmissions, excluding planned readmissions, based on similar specifications for the Maryland Readmission Reduction Incentive Program, but applied to all inpatient discharges and observation stays greater than 23 hours. The readmission revenue is assigned to the hospital receiving the readmission regardless of where the original admission occurred.
- Prevention quality indicators (PQIs) as defined by the Agency for Healthcare Research and Quality applied to all inpatient discharges and observation stays greater than 23 hours. The PAU cost measure includes the 12 acute and chronic PQIs of the PQI-90 Composite measure and PQI 02 (Perforated Appendix). It does not include PQI 09 (low birth weight).

Readmissions refer to the methodology for the Readmissions Reduction Incentive Program that measures performance using the 30-day all-payer all-hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based on discharge All Patient Refined Diagnosis Related Group Severity of Illness) and planned admissions. The case-mix adjusted readmission rate is assigned to the index hospital and only includes inpatient discharges.

PPCs consist of a list of 65 measures developed by 3M. PPCs are defined as harmful events (e.g., an accidental laceration during a procedure) or negative outcomes (e.g., hospital-acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease. The conditions are excluded if present on admission indicators show that the patient arrived at the hospital with the condition. Hospital payment is linked to hospital performance by comparing the observed number of PPCs to the expected number of PPCs. In this report, the HSCRC only provides the case-mix adjusted PPC rate and not the revenue associated with PPCs.

Direct Graduate Medical Education Expenditures consist of the costs directly related to the training of residents. These costs include stipends and fringe benefits of the residents and the salaries and fringe benefits of the faculty who supervise the residents.

Financial information contained in this report provides only an overview of the total financial status of the institutions. Additional information concerning the hospitals, in the form of Audited Financial Statements and reports filed pursuant to the regulations of the HSCRC, is available at the HSCRC's offices for public inspection between the hours of 8:30 a.m. and 4:30 p.m. and in PDF under Financial Data Reports/Financial Disclosure on the HSCRC website at http://www.hscrc.state.md.us.

NOTES TO THE FINANCIAL AND STATISTICAL DATA

1. Admissions include infants transferred to neo-natal intensive care units in the hospital in which they were born.
2. Revenues and expenses applicable to physician Medicare Part B professional services are only included in regulated hospital data in hospitals that had HSCRC-approved physician rates on June 30, 1985, and that have not subsequently requested that those rates be removed so that the physicians may bill Medicare FFS.
3. The specialty hospitals in this report are: Adventist Behavioral Health Care-Rockville, Adventist Rehabilitation Hospital of Maryland, Brook Lane Health Services, Adventist Behavioral Health-Eastern Shore, Levindale Hospital, Mt. Washington Pediatric Hospital, and Sheppard Pratt Hospital.
4. In accordance with Health-General Article, Section 19-3A-07, three free-standing medical facilities—Queen Anne's Freestanding Medical Center, Germantown Emergency Center, and Bowie Health Center—fall under the rate-setting jurisdiction of the HSCRC. The HSCRC sets rates for all payers for emergency services provided at Queen Anne's Freestanding Medical Center effective October 1, 2010, and at Germantown Emergency Center and Bowie Health Center effective July 1, 2011.
5. Effective July 1, 2013, data associated with the University of Maryland Cancer Center was combined with that of the University of Maryland Medical Center.
6. Effective January 1, 2014, Levindale Hospital was designated by CMS as an acute care hospital, rather than a specialty hospital.
7. Effective October 1, 2014, Holy Cross Germantown Hospital was issued a rate order to begin business in Maryland as an acute care hospital. The data included in this report contain nine months of data (October 1, 2014 to June 30, 2015) for Holy Cross Germantown Hospital's first annual filing.

DETAILS OF THE DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA: ACUTE HOSPITALS

HEALTH SERVICES COST REVIEW COMMISSION

DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

FISCAL YEAR 2014 TO 2016

ALL ACUTE HOSPITALS

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	16,414,062,529	16,023,174,651	15,674,388,126
Unregulated Services	1,767,905,021	1,765,339,383	1,775,574,672
TOTAL	18,181,967,550	17,788,514,034	17,449,962,798
Net Patient Revenue (NPR):			
Regulated Services	13,918,979,932	13,417,265,413	12,840,037,696
Unregulated Services	832,676,315	831,105,191	803,304,981
TOTAL	14,751,656,247	14,248,370,604	13,643,342,677
Other Operating Revenue:			
Regulated Services	160,718,431	207,012,377	202,547,501
Unregulated Services	665,160,514	557,485,573	470,054,013
TOTAL	825,878,945	764,497,950	672,601,514
Net Operating Revenue (NOR)			
Regulated Services	14,079,698,363	13,624,277,791	13,042,585,197
Unregulated Services	1,497,836,829	1,388,590,764	1,273,358,994
Total	15,577,535,193	15,012,868,554	14,315,944,191
Total Operating Expenses:			
Regulated Services	12,874,250,706	12,481,365,520	12,104,941,967
Total	15,065,706,428	14,481,119,517	13,904,654,153
Net Operating Profit (Loss):			
Regulated Services	1,205,447,657	1,142,912,171	937,643,255
Unregulated Services	-693,618,892	-611,163,233	-526,353,133
Total	511,828,765	531,748,938	411,290,122
Total Non-Operating Profit (Loss):	-150,036,105	-2,059,614	484,613,004
Non-Operating Revenue	-34,313,381	51,393,310	502,513,301
Non-Operating Expenses	115,722,725	53,452,924	17,900,297
Total Excess Profit (Loss):	361,792,660	529,689,423	895,903,147
% Net Operating Profit of Regulated NOR	8.56	8.39	7.19
% Net Total Operating Profit of Total NOR	3.29	3.54	2.87
% Total Excess Profit of Total Revenue	2.33	3.52	6.05
Total Direct Medical Education:	328,323,025	300,062,898	291,890,966
Inpatient Readmission Charges:	1,134,364,113	1,153,257,694	1,148,047,788
Risk Adjusted Readmission Percent:	11.72%	12.20%	12.78%
Potentially Avoidable Utilization Costs:	1,797,463,863	1,810,182,982	1,776,882,063
Risk Adjusted PPC Rate:	0.73	0.90	1.09

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

ANNE ARUNDEL MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	576,313,300	562,952,500	554,132,400
Unregulated Services	6,941,900	6,805,400	6,868,600
TOTAL	583,255,200	569,757,900	561,001,000
Net Patient Revenue (NPR):			
Regulated Services	497,838,744	477,344,509	451,481,300
Unregulated Services	6,366,700	6,611,300	6,553,400
TOTAL	504,205,444	483,955,809	458,034,700
Other Operating Revenue:			
Regulated Services	5,914,800	7,170,500	7,047,500
Unregulated Services	6,387,900	19,782,400	18,947,490
TOTAL	12,302,700	26,952,900	25,994,990
Net Operating Revenue (NOR)			
Regulated Services	503,753,544	484,515,009	458,528,800
Unregulated Services	12,754,600	26,393,700	25,500,890
Total	516,508,144	510,908,709	484,029,690
Total Operating Expenses:			
Regulated Services	451,531,237	437,421,849	433,202,797
Total	491,019,800	486,102,500	471,917,600
Net Operating Profit (Loss):			
Regulated Services	52,222,307	47,093,161	25,326,003
Unregulated Services	-26,733,963	-22,286,951	-13,213,903
Total	25,488,344	24,806,209	12,112,100
Total Non-Operating Profit (Loss):	-37,898,800	-40,992,000	27,091,100
Non-Operating Revenue	-37,898,800	-40,992,000	27,091,100
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-12,410,456	-16,185,791	39,203,200
% Net Operating Profit of Regulated NOR	10.37	9.72	5.52
% Net Total Operating Profit of Total NOR	4.93	4.86	2.50
% Total Excess Profit of Total Revenue	-2.59	-3.44	7.67
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	28,490,270	28,653,303	26,732,221
Risk Adjusted Readmission Percent:	11.10%	11.48%	11.91%
Potentially Avoidable Utilization Costs:	51,728,214	50,916,784	46,056,292
Risk Adjusted PPC Rate:	0.73	0.99	1.13

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

ATLANTIC GENERAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	105,461,500	102,371,000	102,693,200
Unregulated Services	50,662,326	42,556,300	25,414,008
TOTAL	156,123,826	144,927,300	128,107,208
Net Patient Revenue (NPR):			
Regulated Services	90,081,400	88,616,700	89,143,246
Unregulated Services	21,406,426	17,503,300	13,780,408
TOTAL	111,487,826	106,120,000	102,923,654
Other Operating Revenue:			
Regulated Services	794,324	1,315,700	1,310,947
Unregulated Services	2,782,807	1,767,100	1,213,122
TOTAL	3,577,131	3,082,800	2,524,069
Net Operating Revenue (NOR)			
Regulated Services	90,875,724	89,932,400	90,454,193
Unregulated Services	24,189,233	19,270,400	14,993,530
Total	115,064,957	109,202,800	105,447,723
Total Operating Expenses:			
Regulated Services	75,915,305	75,395,800	76,554,862
Total	112,904,611	108,320,800	101,635,006
Net Operating Profit (Loss):			
Regulated Services	14,960,419	14,536,600	13,899,332
Unregulated Services	-12,800,074	-13,654,600	-10,086,613
Total	2,160,346	882,000	3,812,719
Total Non-Operating Profit (Loss):	263,569	1,560,200	2,461,360
Non-Operating Revenue	263,569	1,560,200	2,461,360
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	2,423,915	2,442,300	6,274,080
% Net Operating Profit of Regulated NOR	16.46	16.16	15.37
% Net Total Operating Profit of Total NOR	1.88	0.81	3.62
% Total Excess Profit of Total Revenue	2.10	2.20	5.81
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	3,487,090	4,908,066	5,486,337
Risk Adjusted Readmission Percent:	8.82%	10.32%	11.68%
Potentially Avoidable Utilization Costs:	8,449,177	10,602,350	11,055,167
Risk Adjusted PPC Rate:	0.57	0.86	0.88

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

BON SECOURS HOSPITAL

FISCAL YEAR ENDING	August 2016	August 2015	August 2014
Gross Patient Revenue:			
Regulated Services	106,732,300	117,217,800	129,714,300
Unregulated Services	56,474,022	36,444,670	26,341,350
TOTAL	163,206,322	153,662,470	156,055,650
Net Patient Revenue (NPR):			
Regulated Services	90,580,150	98,069,566	99,985,454
Unregulated Services	15,365,284	16,757,466	15,078,939
TOTAL	105,945,434	114,827,031	115,064,392
Other Operating Revenue:			
Regulated Services	1,545,300	800,398	1,585,024
Unregulated Services	3,587,084	3,812,977	4,245,338
TOTAL	5,132,384	4,613,375	5,830,362
Net Operating Revenue (NOR)			
Regulated Services	92,125,450	98,869,964	101,570,478
Unregulated Services	18,952,368	20,570,443	19,324,277
Total	111,077,818	119,440,406	120,894,754
Total Operating Expenses:			
Regulated Services	78,575,804	78,959,061	85,614,206
Total	114,507,342	110,395,175	118,891,000
Net Operating Profit (Loss):			
Regulated Services	13,549,646	19,910,902	15,956,273
Unregulated Services	-16,979,170	-10,865,671	-13,952,517
Total	-3,429,524	9,045,231	2,003,755
Total Non-Operating Profit (Loss):	252,138	299,000	1,565,750
Non-Operating Revenue	464,567	299,000	1,565,750
Non-Operating Expenses	212,429	0	0
Total Excess Profit (Loss):	-3,177,386	9,344,231	3,569,505
% Net Operating Profit of Regulated NOR	14.71	20.14	15.71
% Net Total Operating Profit of Total NOR	-3.09	7.57	1.66
% Total Excess Profit of Total Revenue	-2.85	7.80	2.91
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	13,690,317	18,305,374	22,179,359
Risk Adjusted Readmission Percent:	14.37%	15.33%	17.97%
Potentially Avoidable Utilization Costs:	19,946,234	25,252,547	31,238,308
Risk Adjusted PPC Rate:	1.13	0.80	0.65

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

BOWIE EMERGENCY CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	20,228,300	20,111,300	16,513,400
Unregulated Services	9,901,346	10,142,311	9,852,802
TOTAL	30,129,646	30,253,611	26,366,202
Net Patient Revenue (NPR):			
Regulated Services	13,863,985	14,488,830	12,399,706
Unregulated Services	4,285,990	4,223,356	4,648,934
TOTAL	18,149,975	18,712,186	17,048,641
Other Operating Revenue:			
Regulated Services	297,700	189,930	867
Unregulated Services	1,457,694	0	0
TOTAL	1,755,394	189,930	867
Net Operating Revenue (NOR)			
Regulated Services	14,161,685	14,678,760	12,400,574
Unregulated Services	5,743,684	4,223,356	4,648,934
Total	19,905,369	18,902,116	17,049,508
Total Operating Expenses:			
Regulated Services	12,614,803	12,222,939	10,457,177
Total	18,564,439	17,267,715	15,071,710
Net Operating Profit (Loss):			
Regulated Services	1,546,882	2,455,821	1,943,397
Unregulated Services	-205,952	-821,420	34,401
Total	1,340,930	1,634,401	1,977,798
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	1,340,930	1,634,401	1,977,798
% Net Operating Profit of Regulated NOR	10.92	16.73	15.67
% Net Total Operating Profit of Total NOR	6.74	8.65	11.60
% Total Excess Profit of Total Revenue	6.74	8.65	11.60
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	0	0	0
Risk Adjusted Readmission Percent:	0.00%	0.00%	0.00%
Potentially Avoidable Utilization Costs:	0	0	0
Risk Adjusted PPC Rate:	0.00	0.00	0.00

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

CALVERT MEMORIAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	146,698,600	144,499,900	141,935,300
Unregulated Services	11,709,220	11,343,400	10,240,860
TOTAL	158,407,820	155,843,300	152,176,160
Net Patient Revenue (NPR):			
Regulated Services	127,343,293	124,641,770	117,478,592
Unregulated Services	5,210,263	5,090,942	4,675,516
TOTAL	132,553,556	129,732,712	122,154,108
Other Operating Revenue:			
Regulated Services	3,163,881	3,869,985	5,148,688
Unregulated Services	1,097,878	1,084,745	952,342
TOTAL	4,261,759	4,954,730	6,101,030
Net Operating Revenue (NOR)			
Regulated Services	130,507,174	128,511,755	122,627,280
Unregulated Services	6,308,142	6,175,687	5,627,858
Total	136,815,315	134,687,442	128,255,139
Total Operating Expenses:			
Regulated Services	111,787,053	109,246,740	105,829,305
Total	129,054,256	124,914,230	119,797,306
Net Operating Profit (Loss):			
Regulated Services	18,720,121	19,265,015	16,797,976
Unregulated Services	-10,959,061	-9,491,803	-8,340,143
Total	7,761,059	9,773,212	8,457,833
Total Non-Operating Profit (Loss):	1,002,915	-2,132,041	-1,655,105
Non-Operating Revenue	1,002,915	281,369	514,608
Non-Operating Expenses	0	2,413,410	2,169,713
Total Excess Profit (Loss):	8,763,974	7,641,171	6,802,728
% Net Operating Profit of Regulated NOR	14.34	14.99	13.70
% Net Total Operating Profit of Total NOR	5.67	7.26	6.59
% Total Excess Profit of Total Revenue	6.36	5.66	5.28
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	7,773,270	6,651,086	5,854,547
Risk Adjusted Readmission Percent:	9.26%	8.68%	8.42%
Potentially Avoidable Utilization Costs:	16,795,543	15,765,999	14,512,556
Risk Adjusted PPC Rate:	0.48	0.68	0.85

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

CARROLL HOSPITAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	254,064,500	254,037,700	251,985,400
Unregulated Services	74,692,123	73,597,756	74,612,637
TOTAL	328,756,623	327,635,456	326,598,037
Net Patient Revenue (NPR):			
Regulated Services	217,990,560	217,722,362	211,421,290
Unregulated Services	32,103,123	33,093,873	33,726,861
TOTAL	250,093,683	250,816,235	245,148,151
Other Operating Revenue:			
Regulated Services	2,468,694	2,597,080	4,639,865
Unregulated Services	2,890,600	1,240,078	961,456
TOTAL	5,359,294	3,837,158	5,601,321
Net Operating Revenue (NOR)			
Regulated Services	220,459,254	220,319,442	216,061,155
Unregulated Services	34,993,723	34,333,951	34,688,317
Total	255,452,977	254,653,393	250,749,472
Total Operating Expenses:			
Regulated Services	199,462,258	199,756,327	189,824,332
Total	239,120,643	238,732,927	229,948,414
Net Operating Profit (Loss):			
Regulated Services	20,996,996	20,563,115	26,236,823
Unregulated Services	-4,664,662	-4,642,649	-5,435,765
Total	16,332,334	15,920,466	20,801,058
Total Non-Operating Profit (Loss):	308,300	-3,927,869	6,354,928
Non-Operating Revenue	8,030,300	1,223,684	9,594,707
Non-Operating Expenses	7,722,000	5,151,553	3,239,779
Total Excess Profit (Loss):	16,640,634	11,992,597	27,155,986
% Net Operating Profit of Regulated NOR	9.52	9.33	12.14
% Net Total Operating Profit of Total NOR	6.39	6.25	8.30
% Total Excess Profit of Total Revenue	6.32	4.69	10.43
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	17,906,994	19,212,722	19,803,411
Risk Adjusted Readmission Percent:	11.49%	11.30%	12.54%
Potentially Avoidable Utilization Costs:	33,931,949	35,728,939	33,718,360
Risk Adjusted PPC Rate:	0.80	1.01	1.23

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

DOCTORS COMMUNITY HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	234,045,500	226,462,500	222,145,400
Unregulated Services	23,864,393	21,074,527	21,497,124
TOTAL	257,909,893	247,537,027	243,642,524
Net Patient Revenue (NPR):			
Regulated Services	196,748,065	186,906,068	178,102,639
Unregulated Services	23,752,910	20,785,043	21,502,253
TOTAL	220,500,975	207,691,111	199,604,892
Other Operating Revenue:			
Regulated Services	-749,478	1,978,080	2,232,490
Unregulated Services	6,451,267	4,961,871	3,242,342
TOTAL	5,701,789	6,939,951	5,474,832
Net Operating Revenue (NOR)			
Regulated Services	195,998,587	188,884,148	180,335,129
Unregulated Services	30,204,177	25,746,914	24,744,595
Total	226,202,764	214,631,062	205,079,724
Total Operating Expenses:			
Regulated Services	179,480,079	170,753,892	170,083,752
Total	220,883,373	208,511,680	204,184,713
Net Operating Profit (Loss):			
Regulated Services	16,518,507	18,130,257	10,251,378
Unregulated Services	-11,199,116	-12,010,875	-9,356,366
Total	5,319,391	6,119,382	895,012
Total Non-Operating Profit (Loss):	-3,921,617	-1,022,687	-243,211
Non-Operating Revenue	708,268	-1,022,687	-243,211
Non-Operating Expenses	4,629,885	0	0
Total Excess Profit (Loss):	1,397,774	5,096,695	651,801
% Net Operating Profit of Regulated NOR	8.43	9.60	5.68
% Net Total Operating Profit of Total NOR	2.35	2.85	0.44
% Total Excess Profit of Total Revenue	0.62	2.39	0.32
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	23,530,584	21,254,010	19,742,079
Risk Adjusted Readmission Percent:	11.97%	11.66%	11.88%
Potentially Avoidable Utilization Costs:	39,904,998	35,733,570	36,131,902
Risk Adjusted PPC Rate:	0.67	1.29	1.17

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

FORT WASHINGTON MEDICAL CENTER

FISCAL YEAR ENDING	December 2015	December 2014	December 2013
Gross Patient Revenue:			
Regulated Services	48,291,192	48,565,970	46,156,625
Unregulated Services	211,142	404,675	391,018
TOTAL	48,502,334	48,970,645	46,547,643
Net Patient Revenue (NPR):			
Regulated Services	41,353,146	40,450,576	37,357,875
Unregulated Services	211,142	404,675	391,018
TOTAL	41,564,288	40,855,251	37,748,893
Other Operating Revenue:			
Regulated Services	802,900	1,345,091	1,717,070
Unregulated Services	51,978	39,088	41,245
TOTAL	854,878	1,384,179	1,758,315
Net Operating Revenue (NOR)			
Regulated Services	42,156,046	41,795,667	39,074,945
Unregulated Services	263,120	443,763	432,263
Total	42,419,166	42,239,430	39,507,208
Total Operating Expenses:			
Regulated Services	41,591,264	39,766,800	37,851,168
Total	42,405,199	40,859,285	38,931,926
Net Operating Profit (Loss):			
Regulated Services	564,782	2,028,867	1,223,777
Unregulated Services	-550,815	-648,722	-648,495
Total	13,967	1,380,145	575,282
Total Non-Operating Profit (Loss):	662	607	748
Non-Operating Revenue	662	607	748
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	14,629	1,380,752	576,030
% Net Operating Profit of Regulated NOR	1.34	4.85	3.13
% Net Total Operating Profit of Total NOR	0.03	3.27	1.46
% Total Excess Profit of Total Revenue	0.03	3.27	1.46
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	2,835,441	3,593,267	3,035,810
Risk Adjusted Readmission Percent:	10.27%	11.57%	13.79%
Potentially Avoidable Utilization Costs:	7,670,868	7,947,365	7,117,927
Risk Adjusted PPC Rate:	0.11	0.33	0.81

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

FREDERICK MEMORIAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	363,795,700	346,609,902	339,660,800
Unregulated Services	57,294,670	57,086,448	69,997,055
TOTAL	421,090,370	403,696,350	409,657,855
Net Patient Revenue (NPR):			
Regulated Services	307,860,058	293,871,610	274,540,716
Unregulated Services	34,082,959	33,379,435	38,893,323
TOTAL	341,943,017	327,251,045	313,434,038
Other Operating Revenue:			
Regulated Services	4,929,135	5,129,913	6,545,338
Unregulated Services	3,388,865	3,124,506	3,683,661
TOTAL	8,318,000	8,254,419	10,228,999
Net Operating Revenue (NOR)			
Regulated Services	312,789,193	299,001,523	281,086,054
Unregulated Services	37,471,824	36,503,941	42,576,984
Total	350,261,017	335,505,464	323,663,037
Total Operating Expenses:			
Regulated Services	278,175,236	274,234,304	264,760,912
Total	331,555,000	324,400,419	320,533,000
Net Operating Profit (Loss):			
Regulated Services	34,613,957	24,767,220	16,325,142
Unregulated Services	-15,907,940	-13,662,174	-13,195,104
Total	18,706,017	11,105,045	3,130,038
Total Non-Operating Profit (Loss):	-6,465,000	579,400	13,863,000
Non-Operating Revenue	4,598,000	7,448,400	16,523,000
Non-Operating Expenses	11,063,000	6,869,000	2,660,000
Total Excess Profit (Loss):	12,241,017	11,684,445	16,993,038
% Net Operating Profit of Regulated NOR	11.07	8.28	5.81
% Net Total Operating Profit of Total NOR	5.34	3.31	0.97
% Total Excess Profit of Total Revenue	3.45	3.41	5.00
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	21,147,063	23,540,648	22,598,572
Risk Adjusted Readmission Percent:	9.60%	10.60%	10.41%
Potentially Avoidable Utilization Costs:	37,620,617	41,299,345	40,249,248
Risk Adjusted PPC Rate:	0.73	0.89	1.02

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

GARRETT COUNTY MEMORIAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	48,479,700	44,693,600	45,202,600
Unregulated Services	13,070,536	12,856,975	7,013,510
TOTAL	61,550,236	57,550,575	52,216,110
Net Patient Revenue (NPR):			
Regulated Services	41,011,099	37,569,611	36,914,781
Unregulated Services	5,059,417	6,048,180	4,252,165
TOTAL	46,070,516	43,617,791	41,166,947
Other Operating Revenue:			
Regulated Services	970,434	1,722,986	1,918,578
Unregulated Services	551,434	329,639	299,663
TOTAL	1,521,868	2,052,625	2,218,241
Net Operating Revenue (NOR)			
Regulated Services	41,981,533	39,292,597	38,833,359
Unregulated Services	5,610,851	6,377,819	4,551,828
Total	47,592,384	45,670,416	43,385,188
Total Operating Expenses:			
Regulated Services	39,247,254	35,427,708	34,661,815
Total	47,660,593	41,597,075	40,023,965
Net Operating Profit (Loss):			
Regulated Services	2,734,279	3,864,889	4,171,544
Unregulated Services	-2,802,488	208,452	-810,322
Total	-68,209	4,073,341	3,361,223
Total Non-Operating Profit (Loss):	334,557	731,976	877,732
Non-Operating Revenue	334,557	731,976	877,732
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	266,348	4,805,317	4,238,955
% Net Operating Profit of Regulated NOR	6.51	9.84	10.74
% Net Total Operating Profit of Total NOR	-0.14	8.92	7.75
% Total Excess Profit of Total Revenue	0.56	10.36	9.58
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	1,107,848	1,359,438	1,292,752
Risk Adjusted Readmission Percent:	6.18%	6.43%	7.23%
Potentially Avoidable Utilization Costs:	3,972,000	4,185,717	4,217,539
Risk Adjusted PPC Rate:	0.69	0.75	1.32

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

GERMANTOWN EMERGENCY CENTER

FISCAL YEAR ENDING	December 2015	December 2014	December 2013
Gross Patient Revenue:			
Regulated Services	13,555,000	14,059,900	12,992,000
Unregulated Services	0	0	0
TOTAL	13,555,000	14,059,900	12,992,000
Net Patient Revenue (NPR):			
Regulated Services	9,691,602	9,216,478	9,389,152
Unregulated Services	0	0	0
TOTAL	9,691,602	9,216,478	9,389,152
Other Operating Revenue:			
Regulated Services	7,183	7,567	14,865
Unregulated Services	251,097	263,000	0
TOTAL	258,280	270,567	14,865
Net Operating Revenue (NOR)			
Regulated Services	9,698,785	9,224,045	9,404,017
Unregulated Services	251,097	263,000	0
Total	9,949,882	9,487,045	9,404,017
Total Operating Expenses:			
Regulated Services	10,835,481	11,106,309	11,094,387
Total	11,148,023	11,406,414	11,289,944
Net Operating Profit (Loss):			
Regulated Services	-1,136,696	-1,882,264	-1,690,370
Unregulated Services	-61,445	-37,105	-195,557
Total	-1,198,141	-1,919,369	-1,885,927
Total Non-Operating Profit (Loss):	-418,018	-407,785	-378,665
Non-Operating Revenue	-418,018	-407,785	-378,665
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-1,616,159	-2,327,154	-2,264,592
% Net Operating Profit of Regulated NOR	-11.72	-20.41	-17.97
% Net Total Operating Profit of Total NOR	-12.04	-20.23	-20.05
% Total Excess Profit of Total Revenue	-16.96	-25.63	-25.09
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	0	0	0
Risk Adjusted Readmission Percent:	0.00%	0.00%	0.00%
Potentially Avoidable Utilization Costs:	0	0	0
Risk Adjusted PPC Rate:	0.00	0.00	0.00

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

GREATER BALTIMORE MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	439,684,200	432,707,700	426,965,000
Unregulated Services	46,382,096	46,277,696	46,343,000
TOTAL	486,066,296	478,985,396	473,308,000
Net Patient Revenue (NPR):			
Regulated Services	378,187,463	369,026,601	357,329,000
Unregulated Services	22,991,225	22,677,372	21,736,100
TOTAL	401,178,688	391,703,973	379,065,100
Other Operating Revenue:			
Regulated Services	8,314,668	8,852,410	8,765,799
Unregulated Services	11,163,100	11,589,157	14,711,200
TOTAL	19,477,768	20,441,567	23,476,999
Net Operating Revenue (NOR)			
Regulated Services	386,502,131	377,879,011	366,094,799
Unregulated Services	34,154,325	34,266,529	36,447,300
Total	420,656,456	412,145,540	402,542,099
Total Operating Expenses:			
Regulated Services	341,360,524	337,071,422	335,132,100
Total	402,047,314	392,458,020	381,697,400
Net Operating Profit (Loss):			
Regulated Services	45,141,607	40,807,589	30,962,700
Unregulated Services	-26,532,465	-21,120,069	-10,118,000
Total	18,609,142	19,687,520	20,844,700
Total Non-Operating Profit (Loss):	-4,946,806	2,623,000	19,695,000
Non-Operating Revenue	-1,754,300	5,100,000	20,282,900
Non-Operating Expenses	3,192,506	2,477,000	587,900
Total Excess Profit (Loss):	13,662,336	22,310,520	40,539,700
% Net Operating Profit of Regulated NOR	11.68	10.80	8.46
% Net Total Operating Profit of Total NOR	4.42	4.78	5.18
% Total Excess Profit of Total Revenue	3.26	5.35	9.59
Total Direct Medical Education:	5,237,160	4,976,560	5,078,600
Inpatient Readmission Charges:	21,748,602	21,097,566	22,000,741
Risk Adjusted Readmission Percent:	10.13%	10.75%	10.71%
Potentially Avoidable Utilization Costs:	37,196,364	35,619,123	37,088,737
Risk Adjusted PPC Rate:	1.00	1.18	1.20

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

HOLY CROSS HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	505,712,400	480,562,300	468,876,700
Unregulated Services	34,043,625	29,149,790	28,978,500
TOTAL	539,756,025	509,712,090	497,855,200
Net Patient Revenue (NPR):			
Regulated Services	418,354,058	400,831,157	382,981,000
Unregulated Services	15,991,950	13,882,068	14,213,000
TOTAL	434,346,008	414,713,225	397,194,000
Other Operating Revenue:			
Regulated Services	3,375,639	4,612,845	6,272,300
Unregulated Services	10,438,166	10,728,100	10,731,690
TOTAL	13,813,805	15,340,945	17,003,990
Net Operating Revenue (NOR)			
Regulated Services	421,729,698	405,444,002	389,253,300
Unregulated Services	26,430,116	24,610,168	24,944,690
Total	448,159,813	430,054,170	414,197,990
Total Operating Expenses:			
Regulated Services	362,874,686	354,456,924	348,206,775
Total	413,238,146	398,445,304	390,903,000
Net Operating Profit (Loss):			
Regulated Services	58,855,012	50,987,078	41,046,525
Unregulated Services	-23,933,345	-19,378,211	-17,751,525
Total	34,921,667	31,608,866	23,295,000
Total Non-Operating Profit (Loss):	-6,083,400	6,093,296	23,263,000
Non-Operating Revenue	-6,083,400	6,093,296	23,263,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	28,838,267	37,702,162	46,558,000
% Net Operating Profit of Regulated NOR	13.96	12.58	10.54
% Net Total Operating Profit of Total NOR	7.79	7.35	5.62
% Total Excess Profit of Total Revenue	6.52	8.64	10.64
Total Direct Medical Education:	2,708,039	2,658,000	2,757,760
Inpatient Readmission Charges:	40,617,410	38,364,441	34,270,651
Risk Adjusted Readmission Percent:	11.70%	11.83%	11.63%
Potentially Avoidable Utilization Costs:	61,529,272	57,267,855	53,242,560
Risk Adjusted PPC Rate:	0.59	0.84	1.27

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

HOLY CROSS HOSPITAL-GERMANTOWN

FISCAL YEAR ENDING	June 2016	June 2015	
Gross Patient Revenue:			
Regulated Services	80,883,300	43,305,400	0
Unregulated Services	797,132	102,457	0
TOTAL	81,680,432	43,407,857	0
Net Patient Revenue (NPR):			
Regulated Services	65,244,750	36,057,303	0
Unregulated Services	797,132	102,457	0
TOTAL	66,041,882	36,159,760	0
Other Operating Revenue:			
Regulated Services	395,900	313,191	0
Unregulated Services	573,207	461,781	0
TOTAL	969,107	774,972	0
Net Operating Revenue (NOR)			
Regulated Services	65,640,650	36,370,494	0
Unregulated Services	1,370,338	564,238	0
Total	67,010,988	36,934,732	0
Total Operating Expenses:			
Regulated Services	76,357,033	56,371,837	0
Total	86,826,724	62,122,512	0
Net Operating Profit (Loss):			
Regulated Services	-10,716,383	-20,001,343	0
Unregulated Services	-9,099,352	-5,186,437	0
Total	-19,815,736	-25,187,780	0
Total Non-Operating Profit (Loss):	-698,359	-142,227	0
Non-Operating Revenue	-698,359	-142,227	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-20,514,095	-25,330,007	0
% Net Operating Profit of Regulated NOR	-16.33	-54.99	0.00
% Net Total Operating Profit of Total NOR	-29.57	-68.20	0.00
% Total Excess Profit of Total Revenue	-30.94	-68.85	0.00
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	6,016,684	3,964,502	0
Risk Adjusted Readmission Percent:	10.48%	11.41%	0.00%
Potentially Avoidable Utilization Costs:	11,097,273	7,708,302	0
Risk Adjusted PPC Rate:	0.61	0.70	0.00

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

HOWARD COUNTY GENERAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	297,946,200	286,302,800	281,805,600
Unregulated Services	0	0	0
TOTAL	297,946,200	286,302,800	281,805,600
Net Patient Revenue (NPR):			
Regulated Services	257,850,200	242,889,800	232,598,600
Unregulated Services	0	0	0
TOTAL	257,850,200	242,889,800	232,598,600
Other Operating Revenue:			
Regulated Services	1,379,422	2,048,754	62,249
Unregulated Services	2,386,147	2,508,749	1,995,674
TOTAL	3,765,569	4,557,503	2,057,923
Net Operating Revenue (NOR)			
Regulated Services	259,229,622	244,938,554	232,660,849
Unregulated Services	2,386,147	2,508,749	1,995,674
Total	261,615,769	247,447,303	234,656,523
Total Operating Expenses:			
Regulated Services	242,053,450	227,890,658	222,265,553
Total	252,094,167	237,009,512	231,079,634
Net Operating Profit (Loss):			
Regulated Services	17,176,172	17,047,896	10,395,296
Unregulated Services	-7,654,570	-6,610,105	-6,818,406
Total	9,521,602	10,437,791	3,576,890
Total Non-Operating Profit (Loss):	-4,911,402	-1,238,991	6,309,706
Non-Operating Revenue	3,515,431	2,137,497	4,133,076
Non-Operating Expenses	8,426,833	3,376,488	-2,176,630
Total Excess Profit (Loss):	4,610,200	9,198,800	9,886,601
% Net Operating Profit of Regulated NOR	6.63	6.96	4.47
% Net Total Operating Profit of Total NOR	3.64	4.22	1.52
% Total Excess Profit of Total Revenue	1.74	3.69	4.14
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	21,670,556	21,347,026	24,538,782
Risk Adjusted Readmission Percent:	11.63%	11.34%	12.39%
Potentially Avoidable Utilization Costs:	36,991,838	35,291,511	38,297,145
Risk Adjusted PPC Rate:	0.76	0.88	1.36

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	643,455,400	618,220,800	605,106,300
Unregulated Services	4,755,600	4,222,500	4,406,900
TOTAL	648,211,000	622,443,300	609,513,200
Net Patient Revenue (NPR):			
Regulated Services	535,127,100	507,487,100	484,348,000
Unregulated Services	4,268,600	3,850,500	3,663,900
TOTAL	539,395,700	511,337,600	488,011,900
Other Operating Revenue:			
Regulated Services	7,814,000	8,098,100	9,049,099
Unregulated Services	56,333,300	55,593,100	42,960,500
TOTAL	64,147,300	63,691,200	52,009,599
Net Operating Revenue (NOR)			
Regulated Services	542,941,100	515,585,200	493,397,099
Unregulated Services	60,601,900	59,443,600	46,624,400
Total	603,543,000	575,028,800	540,021,499
Total Operating Expenses:			
Regulated Services	530,778,637	498,586,635	472,155,588
Total	596,562,000	563,029,000	530,603,000
Net Operating Profit (Loss):			
Regulated Services	12,162,463	16,998,565	21,241,512
Unregulated Services	-5,181,463	-4,998,765	-11,823,012
Total	6,981,000	11,999,800	9,418,500
Total Non-Operating Profit (Loss):	2,133,900	1,875,200	1,686,500
Non-Operating Revenue	2,133,900	1,875,200	1,686,500
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	9,114,900	13,875,000	11,105,000
% Net Operating Profit of Regulated NOR	2.24	3.30	4.31
% Net Total Operating Profit of Total NOR	1.16	2.09	1.74
% Total Excess Profit of Total Revenue	1.50	2.41	2.05
Total Direct Medical Education:	22,135,500	22,227,000	21,979,800
Inpatient Readmission Charges:	51,248,946	48,715,813	50,358,227
Risk Adjusted Readmission Percent:	14.14%	14.35%	15.27%
Potentially Avoidable Utilization Costs:	77,369,945	72,537,973	73,151,486
Risk Adjusted PPC Rate:	0.49	0.79	0.84

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

JOHNS HOPKINS HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	2,282,683,400	2,209,868,500	2,172,517,900
Unregulated Services	9,641,276	7,110,016	12,351,327
TOTAL	2,292,324,676	2,216,978,516	2,184,869,227
Net Patient Revenue (NPR):			
Regulated Services	1,916,625,561	1,839,752,921	1,778,796,357
Unregulated Services	9,641,276	5,444,904	10,509,115
TOTAL	1,926,266,837	1,845,197,825	1,789,305,472
Other Operating Revenue:			
Regulated Services	15,291,999	14,952,526	14,656,180
Unregulated Services	257,292,975	196,988,003	155,742,900
TOTAL	272,584,974	211,940,529	170,399,080
Net Operating Revenue (NOR)			
Regulated Services	1,931,917,560	1,854,705,447	1,793,452,537
Unregulated Services	266,934,251	202,432,907	166,252,015
Total	2,198,851,811	2,057,138,354	1,959,704,552
Total Operating Expenses:			
Regulated Services	1,904,995,652	1,842,294,064	1,768,501,426
Total	2,173,349,352	2,047,447,655	1,928,276,090
Net Operating Profit (Loss):			
Regulated Services	26,921,908	12,411,383	24,951,117
Unregulated Services	-1,419,449	-2,720,684	6,477,361
Total	25,502,459	9,690,699	31,428,478
Total Non-Operating Profit (Loss):	36,798,309	39,589,768	35,421,690
Non-Operating Revenue	36,798,309	39,589,768	35,421,690
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	62,300,768	49,280,467	66,850,174
% Net Operating Profit of Regulated NOR	1.39	0.67	1.39
% Net Total Operating Profit of Total NOR	1.16	0.47	1.60
% Total Excess Profit of Total Revenue	2.79	2.35	3.35
Total Direct Medical Education:	108,442,934	110,114,790	103,050,920
Inpatient Readmission Charges:	162,859,391	163,571,963	164,047,904
Risk Adjusted Readmission Percent:	13.22%	14.23%	14.86%
Potentially Avoidable Utilization Costs:	204,204,206	204,203,207	202,679,689
Risk Adjusted PPC Rate:	0.77	0.91	1.04

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

LAUREL REGIONAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	106,117,500	106,467,900	118,865,000
Unregulated Services	1,985,672	1,517,991	5,189,156
TOTAL	108,103,172	107,985,891	124,054,156
Net Patient Revenue (NPR):			
Regulated Services	90,443,295	90,359,092	97,912,231
Unregulated Services	1,419,848	123,792	1,501,121
TOTAL	91,863,143	90,482,885	99,413,352
Other Operating Revenue:			
Regulated Services	1,193,454	1,509,271	2,735,242
Unregulated Services	249,504	276,336	306,036
TOTAL	1,442,958	1,785,607	3,041,278
Net Operating Revenue (NOR)			
Regulated Services	91,636,749	91,868,363	100,647,473
Unregulated Services	1,669,352	400,129	1,807,157
Total	93,306,101	92,268,492	102,454,630
Total Operating Expenses:			
Regulated Services	85,066,992	96,291,469	104,245,610
Total	97,371,992	108,774,321	111,690,619
Net Operating Profit (Loss):			
Regulated Services	6,569,757	-4,423,106	-3,598,137
Unregulated Services	-10,635,648	-12,082,723	-5,637,852
Total	-4,065,891	-16,505,829	-9,235,989
Total Non-Operating Profit (Loss):	2,833,438	7,391,088	8,550,000
Non-Operating Revenue	2,833,438	7,391,088	8,550,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-1,232,453	-9,114,741	-685,989
% Net Operating Profit of Regulated NOR	7.17	-4.81	-3.57
% Net Total Operating Profit of Total NOR	-4.36	-17.89	-9.01
% Total Excess Profit of Total Revenue	-1.28	-9.15	-0.62
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	7,778,186	7,679,937	7,478,142
Risk Adjusted Readmission Percent:	12.13%	13.15%	13.52%
Potentially Avoidable Utilization Costs:	12,699,645	12,793,751	12,772,626
Risk Adjusted PPC Rate:	0.99	1.14	1.07

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

LEVINDALE

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	60,312,800	59,785,479	54,541,800
Unregulated Services	32,666,054	32,727,172	35,343,587
TOTAL	92,978,854	92,512,651	89,885,387
Net Patient Revenue (NPR):			
Regulated Services	48,514,862	46,832,627	47,571,840
Unregulated Services	26,134,537	26,559,417	28,791,830
TOTAL	74,649,399	73,392,044	76,363,670
Other Operating Revenue:			
Regulated Services	2,098,512	823,334	1,640,083
Unregulated Services	172,329	206,374	54,975
TOTAL	2,270,841	1,029,708	1,695,058
Net Operating Revenue (NOR)			
Regulated Services	50,613,374	47,655,961	49,211,923
Unregulated Services	26,306,866	26,765,791	28,846,805
Total	76,920,240	74,421,752	78,058,728
Total Operating Expenses:			
Regulated Services	41,623,303	39,404,902	42,154,535
Total	72,536,873	72,621,228	74,832,787
Net Operating Profit (Loss):			
Regulated Services	8,990,071	8,251,059	7,057,388
Unregulated Services	-4,606,704	-6,450,535	-3,831,447
Total	4,383,367	1,800,524	3,225,941
Total Non-Operating Profit (Loss):	-457,179	-1,019,876	3,575,884
Non-Operating Revenue	-457,179	-1,019,876	3,575,884
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	3,926,188	780,648	6,801,826
% Net Operating Profit of Regulated NOR	17.76	17.31	14.34
% Net Total Operating Profit of Total NOR	5.70	2.42	4.13
% Total Excess Profit of Total Revenue	5.13	1.06	8.33
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	4,350,683	4,042,561	3,625,955
Risk Adjusted Readmission Percent:	11.20%	13.10%	12.56%
Potentially Avoidable Utilization Costs:	4,350,683	4,054,007	3,625,955
Risk Adjusted PPC Rate:	2.71	4.69	0.00

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MCCREADY MEMORIAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	16,309,200	15,059,800	16,638,000
Unregulated Services	1,946,141	1,255,944	1,397,602
TOTAL	18,255,341	16,315,744	18,035,602
Net Patient Revenue (NPR):			
Regulated Services	12,659,083	11,880,053	14,019,441
Unregulated Services	1,605,431	771,294	863,487
TOTAL	14,264,514	12,651,347	14,882,928
Other Operating Revenue:			
Regulated Services	587,954	784,050	1,301,193
Unregulated Services	2,520	48,108	83,844
TOTAL	590,474	832,158	1,385,037
Net Operating Revenue (NOR)			
Regulated Services	13,247,037	12,664,103	15,320,634
Unregulated Services	1,607,951	819,402	947,331
Total	14,854,988	13,483,505	16,267,965
Total Operating Expenses:			
Regulated Services	14,666,429	13,220,754	12,257,596
Total	15,628,165	13,993,311	13,788,378
Net Operating Profit (Loss):			
Regulated Services	-1,419,392	-556,651	3,063,038
Unregulated Services	646,215	46,844	-583,451
Total	-773,177	-509,807	2,479,588
Total Non-Operating Profit (Loss):	74,030	84,305	107,518
Non-Operating Revenue	74,030	84,305	107,518
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-699,147	-425,502	2,587,106
% Net Operating Profit of Regulated NOR	-10.71	-4.40	19.99
% Net Total Operating Profit of Total NOR	-5.20	-3.78	15.24
% Total Excess Profit of Total Revenue	-4.68	-3.14	15.80
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	500,641	359,884	546,719
Risk Adjusted Readmission Percent:	10.64%	7.02%	10.08%
Potentially Avoidable Utilization Costs:	1,420,962	1,324,450	1,717,750
Risk Adjusted PPC Rate:	0.76	2.51	2.33

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MEDSTAR FRANKLIN SQUARE

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	505,736,100	491,172,800	486,467,000
Unregulated Services	186,298,688	175,283,739	192,175,314
TOTAL	692,034,788	666,456,539	678,642,314
Net Patient Revenue (NPR):			
Regulated Services	427,619,940	418,234,842	407,447,444
Unregulated Services	79,471,571	75,371,387	70,000,653
TOTAL	507,091,510	493,606,230	477,448,097
Other Operating Revenue:			
Regulated Services	3,235,505	3,724,142	6,794,480
Unregulated Services	8,346,177	6,802,058	6,316,130
TOTAL	11,581,681	10,526,200	13,110,610
Net Operating Revenue (NOR)			
Regulated Services	430,855,445	421,958,984	414,241,924
Unregulated Services	87,817,747	82,173,445	76,316,783
Total	518,673,192	504,132,430	490,558,707
Total Operating Expenses:			
Regulated Services	385,528,867	382,118,274	373,444,124
Total	508,064,432	486,989,680	469,241,214
Net Operating Profit (Loss):			
Regulated Services	45,326,578	39,840,710	40,797,801
Unregulated Services	-34,717,818	-22,697,960	-19,480,307
Total	10,608,760	17,142,750	21,317,494
Total Non-Operating Profit (Loss):	149,318	199,160	246,061
Non-Operating Revenue	149,318	199,160	246,061
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	10,758,078	17,341,909	21,563,555
% Net Operating Profit of Regulated NOR	10.52	9.44	9.85
% Net Total Operating Profit of Total NOR	2.05	3.40	4.35
% Total Excess Profit of Total Revenue	2.07	3.44	4.39
Total Direct Medical Education:	9,890,754	8,467,280	7,574,040
Inpatient Readmission Charges:	48,923,668	45,185,086	47,308,423
Risk Adjusted Readmission Percent:	12.29%	12.18%	12.83%
Potentially Avoidable Utilization Costs:	79,094,289	74,109,879	75,140,771
Risk Adjusted PPC Rate:	0.68	0.88	0.99

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MEDSTAR GOOD SAMARITAN

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	289,108,800	303,789,300	299,250,000
Unregulated Services	126,937,836	147,196,441	142,342,915
TOTAL	416,046,636	450,985,741	441,592,915
Net Patient Revenue (NPR):			
Regulated Services	246,708,456	247,347,394	242,965,630
Unregulated Services	48,388,024	51,580,271	49,688,130
TOTAL	295,096,480	298,927,665	292,653,760
Other Operating Revenue:			
Regulated Services	2,953,403	5,004,986	7,433,958
Unregulated Services	8,484,797	7,962,520	7,188,325
TOTAL	11,438,200	12,967,505	14,622,283
Net Operating Revenue (NOR)			
Regulated Services	249,661,859	252,352,380	250,399,588
Unregulated Services	56,872,821	59,542,790	56,876,455
Total	306,534,680	311,895,170	307,276,043
Total Operating Expenses:			
Regulated Services	213,937,895	216,682,038	224,965,932
Total	302,367,777	303,538,841	303,307,419
Net Operating Profit (Loss):			
Regulated Services	35,723,964	35,670,341	25,433,656
Unregulated Services	-31,557,061	-27,314,012	-21,465,032
Total	4,166,904	8,356,329	3,968,625
Total Non-Operating Profit (Loss):	1,987,800	2,380,847	3,219
Non-Operating Revenue	1,987,800	2,380,847	43,284
Non-Operating Expenses	0	0	40,065
Total Excess Profit (Loss):	6,154,704	10,737,176	3,971,844
% Net Operating Profit of Regulated NOR	14.31	14.14	10.16
% Net Total Operating Profit of Total NOR	1.36	2.68	1.29
% Total Excess Profit of Total Revenue	1.99	3.42	1.29
Total Direct Medical Education:	5,371,417	3,914,080	3,801,620
Inpatient Readmission Charges:	28,298,303	31,184,987	28,640,389
Risk Adjusted Readmission Percent:	12.62%	12.89%	14.47%
Potentially Avoidable Utilization Costs:	45,848,912	47,923,528	44,645,741
Risk Adjusted PPC Rate:	0.62	0.91	0.86

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MEDSTAR HARBOR HOSPITAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	194,368,900	207,452,600	205,146,300
Unregulated Services	60,489,787	62,562,425	78,505,062
TOTAL	254,858,687	270,015,025	283,651,362
Net Patient Revenue (NPR):			
Regulated Services	167,091,643	164,442,500	171,046,194
Unregulated Services	26,548,660	25,629,647	25,319,070
TOTAL	193,640,304	190,072,147	196,365,264
Other Operating Revenue:			
Regulated Services	3,385,440	4,013,879	5,371,719
Unregulated Services	8,222,079	8,578,338	8,195,974
TOTAL	11,607,519	12,592,218	13,567,693
Net Operating Revenue (NOR)			
Regulated Services	170,477,083	168,456,379	176,417,913
Unregulated Services	34,770,740	34,207,986	33,515,044
Total	205,247,823	202,664,365	209,932,957
Total Operating Expenses:			
Regulated Services	143,567,318	144,974,260	146,516,583
Total	190,376,563	191,580,981	189,700,114
Net Operating Profit (Loss):			
Regulated Services	26,909,765	23,482,119	29,901,331
Unregulated Services	-12,038,506	-12,398,735	-9,668,488
Total	14,871,259	11,083,384	20,232,843
Total Non-Operating Profit (Loss):	-676,135	374,536	506,890
Non-Operating Revenue	316,304	374,536	506,890
Non-Operating Expenses	992,439	0	0
Total Excess Profit (Loss):	14,195,125	11,457,920	20,739,733
% Net Operating Profit of Regulated NOR	15.78	13.94	16.95
% Net Total Operating Profit of Total NOR	7.25	5.47	9.64
% Total Excess Profit of Total Revenue	6.91	5.64	9.86
Total Direct Medical Education:	4,696,418	4,637,050	4,402,330
Inpatient Readmission Charges:	16,436,129	16,226,755	15,034,547
Risk Adjusted Readmission Percent:	13.24%	11.83%	12.60%
Potentially Avoidable Utilization Costs:	27,115,521	26,590,819	25,997,610
Risk Adjusted PPC Rate:	0.55	0.79	1.16

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MEDSTAR MONTGOMERY MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	175,827,977	174,302,200	167,893,100
Unregulated Services	9,723,069	8,452,327	8,493,778
TOTAL	185,551,046	182,754,527	176,386,878
Net Patient Revenue (NPR):			
Regulated Services	150,844,829	147,518,393	141,046,268
Unregulated Services	5,058,651	4,296,785	4,590,335
TOTAL	155,903,480	151,815,179	145,636,603
Other Operating Revenue:			
Regulated Services	3,968,813	3,087,252	2,796,922
Unregulated Services	153,650	172,711	282,582
TOTAL	4,122,463	3,259,963	3,079,504
Net Operating Revenue (NOR)			
Regulated Services	154,813,643	150,605,645	143,843,190
Unregulated Services	5,212,301	4,469,496	4,872,917
Total	160,025,943	155,075,141	148,716,107
Total Operating Expenses:			
Regulated Services	136,647,495	136,227,753	128,893,109
Total	151,876,735	148,463,817	141,655,632
Net Operating Profit (Loss):			
Regulated Services	18,166,147	14,377,892	14,950,082
Unregulated Services	-10,016,939	-7,766,568	-7,889,606
Total	8,149,209	6,611,324	7,060,476
Total Non-Operating Profit (Loss):	1,152	7,758	15,370
Non-Operating Revenue	1,152	7,758	15,370
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	8,150,360	6,619,082	7,075,846
% Net Operating Profit of Regulated NOR	11.73	9.55	10.39
% Net Total Operating Profit of Total NOR	5.09	4.26	4.75
% Total Excess Profit of Total Revenue	5.09	4.27	4.76
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	12,691,070	11,280,874	11,304,931
Risk Adjusted Readmission Percent:	10.38%	11.50%	11.66%
Potentially Avoidable Utilization Costs:	20,984,031	19,920,612	19,600,380
Risk Adjusted PPC Rate:	0.79	1.01	1.32

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	271,938,700	262,672,600	261,812,300
Unregulated Services	27,770,529	9,699,152	10,051,455
TOTAL	299,709,229	272,371,752	271,863,755
Net Patient Revenue (NPR):			
Regulated Services	221,201,757	216,113,395	207,161,288
Unregulated Services	11,041,910	4,606,447	5,415,538
TOTAL	232,243,667	220,719,842	212,576,826
Other Operating Revenue:			
Regulated Services	3,009,259	4,253,655	402,847
Unregulated Services	816,273	833,050	882,941
TOTAL	3,825,532	5,086,705	1,285,788
Net Operating Revenue (NOR)			
Regulated Services	224,211,016	220,367,050	207,564,135
Unregulated Services	11,858,184	5,439,497	6,298,479
Total	236,069,199	225,806,547	213,862,614
Total Operating Expenses:			
Regulated Services	210,251,917	216,259,673	204,401,483
Total	242,526,804	233,355,690	219,466,790
Net Operating Profit (Loss):			
Regulated Services	13,959,099	4,107,378	3,162,651
Unregulated Services	-20,416,703	-11,656,520	-8,766,828
Total	-6,457,604	-7,549,143	-5,604,177
Total Non-Operating Profit (Loss):	670	20,445	21,958
Non-Operating Revenue	670	20,445	21,958
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-6,456,935	-7,528,697	-5,582,219
% Net Operating Profit of Regulated NOR	6.23	1.86	1.52
% Net Total Operating Profit of Total NOR	-2.74	-3.34	-2.62
% Total Excess Profit of Total Revenue	-2.74	-3.33	-2.61
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	23,909,295	25,959,896	26,136,926
Risk Adjusted Readmission Percent:	10.72%	11.84%	11.62%
Potentially Avoidable Utilization Costs:	43,929,211	46,612,789	45,433,836
Risk Adjusted PPC Rate:	0.91	1.03	1.28

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MEDSTAR ST. MARY'S HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	178,043,900	166,124,100	157,936,000
Unregulated Services	11,553,194	12,615,882	12,443,429
TOTAL	189,597,094	178,739,982	170,379,429
Net Patient Revenue (NPR):			
Regulated Services	145,761,191	140,075,188	131,499,627
Unregulated Services	8,895,921	7,713,460	6,799,669
TOTAL	154,657,111	147,788,648	138,299,296
Other Operating Revenue:			
Regulated Services	905,975	3,241,480	2,960,851
Unregulated Services	2,422,716	1,632,552	1,745,067
TOTAL	3,328,691	4,874,032	4,705,918
Net Operating Revenue (NOR)			
Regulated Services	146,667,166	143,316,668	134,460,477
Unregulated Services	11,318,636	9,346,012	8,544,737
Total	157,985,802	152,662,680	143,005,214
Total Operating Expenses:			
Regulated Services	130,856,640	120,822,142	114,203,324
Total	149,998,897	139,396,080	131,503,457
Net Operating Profit (Loss):			
Regulated Services	15,810,526	22,494,526	20,257,153
Unregulated Services	-7,823,621	-9,227,927	-8,755,396
Total	7,986,905	13,266,600	11,501,757
Total Non-Operating Profit (Loss):	460	-8,804	769,829
Non-Operating Revenue	460	-8,804	769,829
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	7,987,366	13,257,796	12,271,586
% Net Operating Profit of Regulated NOR	10.78	15.70	15.07
% Net Total Operating Profit of Total NOR	5.06	8.69	8.04
% Total Excess Profit of Total Revenue	5.06	8.68	8.54
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	10,844,085	8,232,596	9,475,597
Risk Adjusted Readmission Percent:	10.81%	10.31%	11.85%
Potentially Avoidable Utilization Costs:	21,070,529	17,559,485	18,529,015
Risk Adjusted PPC Rate:	0.50	0.73	0.84

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MEDSTAR UNION MEMORIAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	426,343,800	419,374,600	415,164,300
Unregulated Services	130,099,859	137,656,161	153,664,182
TOTAL	556,443,659	557,030,761	568,828,482
Net Patient Revenue (NPR):			
Regulated Services	361,444,621	361,044,332	343,104,896
Unregulated Services	55,829,116	53,324,011	52,362,138
TOTAL	417,273,738	414,368,343	395,467,034
Other Operating Revenue:			
Regulated Services	3,066,146	5,235,322	4,836,762
Unregulated Services	8,885,354	9,315,121	8,902,680
TOTAL	11,951,500	14,550,443	13,739,442
Net Operating Revenue (NOR)			
Regulated Services	364,510,768	366,279,654	347,941,658
Unregulated Services	64,714,470	62,639,133	61,264,818
Total	429,225,238	428,918,786	409,206,476
Total Operating Expenses:			
Regulated Services	320,066,035	323,965,920	301,629,439
Total	424,392,626	420,732,087	394,669,299
Net Operating Profit (Loss):			
Regulated Services	44,444,733	42,313,734	46,312,220
Unregulated Services	-39,612,122	-34,127,034	-31,775,042
Total	4,832,611	8,186,700	14,537,178
Total Non-Operating Profit (Loss):	-617,400	1,393,271	5,852,483
Non-Operating Revenue	-617,400	1,393,271	5,852,483
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	4,215,211	9,579,971	20,389,661
% Net Operating Profit of Regulated NOR	12.19	11.55	13.31
% Net Total Operating Profit of Total NOR	1.13	1.91	3.55
% Total Excess Profit of Total Revenue	0.98	2.23	4.91
Total Direct Medical Education:	14,052,897	11,093,490	11,238,490
Inpatient Readmission Charges:	28,073,287	28,738,541	29,090,790
Risk Adjusted Readmission Percent:	12.09%	12.43%	13.64%
Potentially Avoidable Utilization Costs:	43,389,335	46,490,197	44,071,594
Risk Adjusted PPC Rate:	0.77	0.99	1.17

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MERCY MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	513,599,600	495,805,900	489,187,300
Unregulated Services	729,398	727,940	749,899
TOTAL	514,328,998	496,533,840	489,937,199
Net Patient Revenue (NPR):			
Regulated Services	442,251,408	422,084,601	408,619,365
Unregulated Services	729,398	727,940	749,899
TOTAL	442,980,806	422,812,541	409,369,264
Other Operating Revenue:			
Regulated Services	12,786,038	13,387,504	8,959,900
Unregulated Services	15,405,529	15,057,414	14,885,430
TOTAL	28,191,567	28,444,918	23,845,330
Net Operating Revenue (NOR)			
Regulated Services	455,037,446	435,472,105	417,579,265
Unregulated Services	16,134,927	15,785,354	15,635,329
Total	471,172,373	451,257,459	433,214,594
Total Operating Expenses:			
Regulated Services	435,680,490	415,561,187	403,467,951
Total	461,664,786	440,636,048	426,907,582
Net Operating Profit (Loss):			
Regulated Services	19,356,956	19,910,918	14,111,314
Unregulated Services	-9,849,369	-9,289,507	-7,804,301
Total	9,507,587	10,621,411	6,307,013
Total Non-Operating Profit (Loss):	-1,562,127	5,922,844	9,709,384
Non-Operating Revenue	9,371,416	5,966,826	8,724,168
Non-Operating Expenses	10,933,543	43,982	-985,216
Total Excess Profit (Loss):	7,945,460	16,544,255	16,016,399
% Net Operating Profit of Regulated NOR	4.25	4.57	3.38
% Net Total Operating Profit of Total NOR	2.02	2.35	1.46
% Total Excess Profit of Total Revenue	1.65	3.62	3.62
Total Direct Medical Education:	4,707,423	4,874,380	4,675,330
Inpatient Readmission Charges:	18,129,807	19,146,143	20,559,455
Risk Adjusted Readmission Percent:	11.88%	12.67%	14.47%
Potentially Avoidable Utilization Costs:	28,168,463	29,171,326	31,378,616
Risk Adjusted PPC Rate:	0.65	0.85	1.05

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

MERITUS MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	321,748,760	312,302,400	305,141,600
Unregulated Services	69,776,712	64,034,600	59,470,600
TOTAL	391,525,472	376,337,000	364,612,200
Net Patient Revenue (NPR):			
Regulated Services	261,006,413	256,037,471	247,293,500
Unregulated Services	44,089,120	43,247,127	36,504,200
TOTAL	305,095,532	299,284,598	283,797,700
Other Operating Revenue:			
Regulated Services	-465,632	6,200,021	4,178,200
Unregulated Services	7,759,183	9,609,792	8,868,100
TOTAL	7,293,551	15,809,813	13,046,300
Net Operating Revenue (NOR)			
Regulated Services	260,540,781	262,237,492	251,471,700
Unregulated Services	51,848,303	52,856,919	45,372,300
Total	312,389,083	315,094,411	296,844,000
Total Operating Expenses:			
Regulated Services	247,821,201	249,895,029	246,754,400
Total	299,130,713	298,834,529	292,347,100
Net Operating Profit (Loss):			
Regulated Services	12,719,580	12,342,463	4,717,300
Unregulated Services	538,790	3,917,419	-220,400
Total	13,258,370	16,259,882	4,496,900
Total Non-Operating Profit (Loss):	-34,186,290	2,068,739	14,486,000
Non-Operating Revenue	0	2,068,739	14,486,000
Non-Operating Expenses	34,186,290	0	0
Total Excess Profit (Loss):	-20,927,920	18,328,621	18,982,900
% Net Operating Profit of Regulated NOR	4.88	4.71	1.88
% Net Total Operating Profit of Total NOR	4.24	5.16	1.51
% Total Excess Profit of Total Revenue	-6.70	5.78	6.10
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	22,842,298	23,116,032	23,314,759
Risk Adjusted Readmission Percent:	11.53%	12.06%	11.89%
Potentially Avoidable Utilization Costs:	39,902,439	40,122,294	40,276,326
Risk Adjusted PPC Rate:	0.70	0.96	1.04

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

NORTHWEST HOSPITAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	257,944,700	254,115,900	249,134,500
Unregulated Services	44,070,449	45,875,010	40,289,193
TOTAL	302,015,149	299,990,910	289,423,693
Net Patient Revenue (NPR):			
Regulated Services	213,970,769	208,102,926	198,880,687
Unregulated Services	16,387,321	18,285,149	16,322,685
TOTAL	230,358,090	226,388,075	215,203,372
Other Operating Revenue:			
Regulated Services	2,382,809	1,254,036	2,083,246
Unregulated Services	17,210,368	8,137,819	6,071,930
TOTAL	19,593,177	9,391,855	8,155,176
Net Operating Revenue (NOR)			
Regulated Services	216,353,578	209,356,962	200,963,933
Unregulated Services	33,597,689	26,422,968	22,394,615
Total	249,951,267	235,779,930	223,358,548
Total Operating Expenses:			
Regulated Services	181,171,177	175,840,331	177,499,465
Total	236,039,880	219,326,432	213,902,245
Net Operating Profit (Loss):			
Regulated Services	35,182,401	33,516,631	23,464,469
Unregulated Services	-21,271,014	-17,063,133	-14,008,165
Total	13,911,387	16,453,498	9,456,304
Total Non-Operating Profit (Loss):	-4,775,477	2,338,720	16,161,910
Non-Operating Revenue	-4,775,477	2,338,720	16,161,910
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	9,135,910	18,792,218	25,618,214
% Net Operating Profit of Regulated NOR	16.26	16.01	11.68
% Net Total Operating Profit of Total NOR	5.57	6.98	4.23
% Total Excess Profit of Total Revenue	3.73	7.89	10.70
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	22,916,294	24,503,425	26,371,296
Risk Adjusted Readmission Percent:	12.96%	12.82%	14.61%
Potentially Avoidable Utilization Costs:	41,429,741	43,088,415	44,102,483
Risk Adjusted PPC Rate:	0.80	0.72	0.99

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

PENINSULA REGIONAL MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	430,070,800	422,383,500	416,388,900
Unregulated Services	72,999,700	68,171,900	65,260,800
TOTAL	503,070,500	490,555,400	481,649,700
Net Patient Revenue (NPR):			
Regulated Services	366,877,800	359,583,600	344,224,200
Unregulated Services	29,906,900	26,494,900	24,311,800
TOTAL	396,784,700	386,078,500	368,536,000
Other Operating Revenue:			
Regulated Services	1,314,600	2,474,800	4,808,700
Unregulated Services	6,722,600	5,230,900	2,542,800
TOTAL	8,037,200	7,705,700	7,351,500
Net Operating Revenue (NOR)			
Regulated Services	368,192,400	362,058,400	349,032,900
Unregulated Services	36,629,500	31,725,800	26,854,600
Total	404,821,900	393,784,200	375,887,500
Total Operating Expenses:			
Regulated Services	329,763,075	313,563,770	312,613,046
Total	405,639,700	378,340,200	368,196,500
Net Operating Profit (Loss):			
Regulated Services	38,429,325	48,494,630	36,419,854
Unregulated Services	-39,247,125	-33,050,630	-28,728,854
Total	-817,800	15,444,000	7,691,000
Total Non-Operating Profit (Loss):	7,654,800	8,624,000	21,729,000
Non-Operating Revenue	7,654,800	15,933,000	21,729,000
Non-Operating Expenses	0	7,309,000	0
Total Excess Profit (Loss):	6,837,000	24,068,000	29,420,000
% Net Operating Profit of Regulated NOR	10.44	13.39	10.43
% Net Total Operating Profit of Total NOR	-0.20	3.92	2.05
% Total Excess Profit of Total Revenue	1.66	5.87	7.40
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	26,701,595	29,532,745	27,511,796
Risk Adjusted Readmission Percent:	10.12%	10.92%	11.34%
Potentially Avoidable Utilization Costs:	49,615,121	51,895,249	45,451,953
Risk Adjusted PPC Rate:	0.78	0.69	1.34

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

PRINCE GEORGES HOSPITAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	285,682,600	279,091,000	267,282,400
Unregulated Services	20,080,356	21,066,946	19,068,307
TOTAL	305,762,956	300,157,946	286,350,707
Net Patient Revenue (NPR):			
Regulated Services	253,113,614	237,779,691	218,330,120
Unregulated Services	8,591,716	8,129,982	7,067,837
TOTAL	261,705,330	245,909,673	225,397,957
Other Operating Revenue:			
Regulated Services	4,996,438	6,259,988	3,683,713
Unregulated Services	2,110,695	1,383,449	1,476,428
TOTAL	7,107,133	7,643,437	5,160,141
Net Operating Revenue (NOR)			
Regulated Services	258,110,053	244,039,679	222,013,833
Unregulated Services	10,702,411	9,513,431	8,544,265
Total	268,812,464	253,553,109	230,558,098
Total Operating Expenses:			
Regulated Services	227,352,248	220,302,096	217,477,104
Total	271,879,717	254,630,833	249,691,862
Net Operating Profit (Loss):			
Regulated Services	30,757,805	23,737,583	4,536,729
Unregulated Services	-33,825,058	-24,815,306	-23,670,492
Total	-3,067,254	-1,077,724	-19,133,763
Total Non-Operating Profit (Loss):	7,709,817	18,773,845	22,326,150
Non-Operating Revenue	7,709,817	18,773,845	22,326,150
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	4,642,564	17,696,121	3,192,390
% Net Operating Profit of Regulated NOR	11.92	9.73	2.04
% Net Total Operating Profit of Total NOR	-1.14	-0.43	-8.30
% Total Excess Profit of Total Revenue	1.68	6.50	1.26
Total Direct Medical Education:	5,117,267	4,388,670	3,988,330
Inpatient Readmission Charges:	22,243,088	22,570,858	21,090,536
Risk Adjusted Readmission Percent:	10.33%	10.63%	10.35%
Potentially Avoidable Utilization Costs:	37,547,624	37,393,953	38,092,059
Risk Adjusted PPC Rate:	1.05	0.98	0.88

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

SHADY GROVE ADVENTIST HOSPITAL

FISCAL YEAR ENDING	December 2015	December 2014	December 2013
Gross Patient Revenue:			
Regulated Services	389,913,200	383,323,300	375,189,800
Unregulated Services	6,418,886	21,122,086	27,614,020
TOTAL	396,332,086	404,445,386	402,803,820
Net Patient Revenue (NPR):			
Regulated Services	333,295,244	322,939,414	306,717,029
Unregulated Services	1,835,557	11,062,723	13,372,763
TOTAL	335,130,801	334,002,137	320,089,792
Other Operating Revenue:			
Regulated Services	1,632,076	3,045,364	5,247,337
Unregulated Services	5,933,574	6,356,051	5,820,855
TOTAL	7,565,650	9,401,415	11,068,192
Net Operating Revenue (NOR)			
Regulated Services	334,927,320	325,984,778	311,964,366
Unregulated Services	7,769,131	17,418,774	19,193,618
Total	342,696,451	343,403,552	331,157,984
Total Operating Expenses:			
Regulated Services	295,354,588	294,301,624	283,029,117
Total	316,448,393	326,254,601	315,633,624
Net Operating Profit (Loss):			
Regulated Services	39,572,732	31,683,154	28,935,249
Unregulated Services	-13,324,674	-14,534,203	-13,410,889
Total	26,248,058	17,148,951	15,524,360
Total Non-Operating Profit (Loss):	-968,436	1,178,041	-260,667
Non-Operating Revenue	-968,436	1,178,041	-260,667
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	25,279,622	18,326,992	15,263,693
% Net Operating Profit of Regulated NOR	11.82	9.72	9.28
% Net Total Operating Profit of Total NOR	7.66	4.99	4.69
% Total Excess Profit of Total Revenue	7.40	5.32	4.61
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	24,685,862	26,351,163	24,667,035
Risk Adjusted Readmission Percent:	10.04%	10.34%	10.41%
Potentially Avoidable Utilization Costs:	39,376,946	40,567,442	39,558,594
Risk Adjusted PPC Rate:	0.84	0.84	0.86

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

SINAI HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	732,671,600	717,312,400	699,430,000
Unregulated Services	186,704,461	192,009,500	193,082,993
TOTAL	919,376,061	909,321,900	892,512,993
Net Patient Revenue (NPR):			
Regulated Services	615,507,214	592,096,200	565,895,246
Unregulated Services	74,081,947	83,947,900	83,756,627
TOTAL	689,589,161	676,044,100	649,651,873
Other Operating Revenue:			
Regulated Services	10,332,455	10,212,300	11,819,850
Unregulated Services	56,025,531	49,598,000	41,560,500
TOTAL	66,357,986	59,810,300	53,380,350
Net Operating Revenue (NOR)			
Regulated Services	625,839,669	602,308,500	577,715,096
Unregulated Services	130,107,478	133,545,900	125,317,127
Total	755,947,147	735,854,400	703,032,223
Total Operating Expenses:			
Regulated Services	551,295,426	528,171,600	517,159,092
Total	725,051,986	698,380,500	675,091,241
Net Operating Profit (Loss):			
Regulated Services	74,544,243	74,136,800	60,556,006
Unregulated Services	-43,649,082	-36,663,000	-32,615,013
Total	30,895,161	37,473,800	27,940,993
Total Non-Operating Profit (Loss):	-4,248,000	7,728,000	29,800,000
Non-Operating Revenue	0	7,728,000	29,800,000
Non-Operating Expenses	4,248,000	0	0
Total Excess Profit (Loss):	26,647,161	45,201,800	57,740,993
% Net Operating Profit of Regulated NOR	11.91	12.31	10.48
% Net Total Operating Profit of Total NOR	4.09	5.09	3.97
% Total Excess Profit of Total Revenue	3.53	6.08	7.88
Total Direct Medical Education:	14,784,200	15,453,348	15,265,590
Inpatient Readmission Charges:	45,399,159	46,546,348	47,729,819
Risk Adjusted Readmission Percent:	12.04%	12.74%	14.24%
Potentially Avoidable Utilization Costs:	69,251,695	69,086,164	68,661,075
Risk Adjusted PPC Rate:	0.75	0.74	1.03

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

ST. AGNES HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	432,204,400	418,876,800	410,191,100
Unregulated Services	178,804,137	172,273,343	164,764,875
TOTAL	611,008,537	591,150,143	574,955,975
Net Patient Revenue (NPR):			
Regulated Services	359,834,307	353,198,398	336,783,777
Unregulated Services	78,480,869	74,518,312	69,199,726
TOTAL	438,315,176	427,716,710	405,983,504
Other Operating Revenue:			
Regulated Services	5,114,462	4,998,484	5,698,599
Unregulated Services	5,997,146	5,606,012	5,273,683
TOTAL	11,111,607	10,604,497	10,972,282
Net Operating Revenue (NOR)			
Regulated Services	364,948,769	358,196,882	342,482,376
Unregulated Services	84,478,014	80,124,325	74,473,409
Total	449,426,783	438,321,207	416,955,786
Total Operating Expenses:			
Regulated Services	312,539,167	304,505,439	289,084,013
Total	439,045,002	420,930,671	393,019,853
Net Operating Profit (Loss):			
Regulated Services	52,409,602	53,691,443	53,398,364
Unregulated Services	-42,027,820	-36,300,907	-29,462,430
Total	10,381,782	17,390,536	23,935,933
Total Non-Operating Profit (Loss):	-7,204,699	1,309,904	20,935,447
Non-Operating Revenue	-7,204,699	1,309,904	22,133,540
Non-Operating Expenses	0	0	1,198,093
Total Excess Profit (Loss):	3,177,083	18,700,440	44,871,382
% Net Operating Profit of Regulated NOR	14.36	14.99	15.59
% Net Total Operating Profit of Total NOR	2.31	3.97	5.74
% Total Excess Profit of Total Revenue	0.72	4.25	10.22
Total Direct Medical Education:	7,229,390	6,863,970	6,888,070
Inpatient Readmission Charges:	35,148,649	36,778,276	38,590,419
Risk Adjusted Readmission Percent:	12.68%	12.41%	13.74%
Potentially Avoidable Utilization Costs:	60,526,198	62,260,988	63,333,408
Risk Adjusted PPC Rate:	0.62	0.81	1.04

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

SUBURBAN HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	301,899,200	295,844,600	289,286,600
Unregulated Services	2,268,518	2,426,100	9,632,810
TOTAL	304,167,718	298,270,700	298,919,410
Net Patient Revenue (NPR):			
Regulated Services	260,794,287	248,692,415	239,648,239
Unregulated Services	2,240,705	2,155,565	3,624,514
TOTAL	263,034,992	250,847,980	243,272,753
Other Operating Revenue:			
Regulated Services	2,576,865	14,154,340	2,720,835
Unregulated Services	21,776,135	10,102,660	18,648,960
TOTAL	24,353,000	24,257,000	21,369,795
Net Operating Revenue (NOR)			
Regulated Services	263,371,152	262,846,755	242,369,074
Unregulated Services	24,016,840	12,258,225	22,273,474
Total	287,387,992	275,104,980	264,642,548
Total Operating Expenses:			
Regulated Services	236,670,658	226,375,634	225,204,531
Total	270,459,430	262,880,000	262,016,800
Net Operating Profit (Loss):			
Regulated Services	26,700,494	36,471,122	17,164,544
Unregulated Services	-9,771,932	-24,246,141	-14,538,791
Total	16,928,562	12,224,980	2,625,753
Total Non-Operating Profit (Loss):	-6,697,000	-2,411,000	13,775,934
Non-Operating Revenue	457,000	615,000	14,727,120
Non-Operating Expenses	7,154,000	3,026,000	951,186
Total Excess Profit (Loss):	10,231,562	9,813,980	16,401,687
% Net Operating Profit of Regulated NOR	10.14	13.88	7.08
% Net Total Operating Profit of Total NOR	5.89	4.44	0.99
% Total Excess Profit of Total Revenue	3.55	3.56	5.87
Total Direct Medical Education:	331,245	339,710	314,920
Inpatient Readmission Charges:	21,112,537	20,017,113	19,789,070
Risk Adjusted Readmission Percent:	10.55%	11.04%	10.81%
Potentially Avoidable Utilization Costs:	32,148,925	30,024,420	29,130,088
Risk Adjusted PPC Rate:	0.73	1.01	1.38

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-BALTIMORE WASHINGTON MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	413,064,200	402,010,800	393,181,900
Unregulated Services	4,327,000	32,849,000	28,963,224
TOTAL	417,391,200	434,859,800	422,145,124
Net Patient Revenue (NPR):			
Regulated Services	355,972,969	340,775,694	320,033,920
Unregulated Services	1,661,998	14,655,742	11,367,399
TOTAL	357,634,967	355,431,436	331,401,319
Other Operating Revenue:			
Regulated Services	1,717,392	1,296,993	2,304,240
Unregulated Services	1,878,608	1,652,007	1,694,936
TOTAL	3,596,000	2,949,000	3,999,176
Net Operating Revenue (NOR)			
Regulated Services	357,690,361	342,072,687	322,338,160
Unregulated Services	3,540,607	16,307,749	13,062,335
Total	361,230,967	358,380,436	335,400,495
Total Operating Expenses:			
Regulated Services	322,713,452	303,700,098	296,252,216
Total	330,823,000	328,186,000	319,029,811
Net Operating Profit (Loss):			
Regulated Services	34,976,908	38,372,589	26,085,945
Unregulated Services	-4,568,941	-8,178,153	-9,715,260
Total	30,407,967	30,194,436	16,370,685
Total Non-Operating Profit (Loss):	-5,491,000	-3,607,000	3,103,363
Non-Operating Revenue	0	0	6,430,980
Non-Operating Expenses	5,491,000	3,607,000	3,327,617
Total Excess Profit (Loss):	24,916,967	26,587,436	19,474,047
% Net Operating Profit of Regulated NOR	9.78	11.22	8.09
% Net Total Operating Profit of Total NOR	8.42	8.43	4.88
% Total Excess Profit of Total Revenue	6.90	7.42	5.70
Total Direct Medical Education:	628,161	422,730	421,820
Inpatient Readmission Charges:	37,259,973	38,023,906	37,547,664
Risk Adjusted Readmission Percent:	12.65%	13.62%	13.92%
Potentially Avoidable Utilization Costs:	62,938,779	62,569,491	60,570,144
Risk Adjusted PPC Rate:	0.65	0.84	1.06

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-CHARLES REGIONAL MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	148,692,700	148,386,400	144,785,724
Unregulated Services	1,451,471	1,069,773	790,489
TOTAL	150,144,171	149,456,173	145,576,213
Net Patient Revenue (NPR):			
Regulated Services	126,752,451	123,706,426	118,662,627
Unregulated Services	848,732	722,392	579,067
TOTAL	127,601,183	124,428,818	119,241,694
Other Operating Revenue:			
Regulated Services	288,272	53,527	28,963
Unregulated Services	420,568	490,473	481,289
TOTAL	708,840	544,000	510,252
Net Operating Revenue (NOR)			
Regulated Services	127,040,723	123,759,953	118,691,590
Unregulated Services	1,269,300	1,212,865	1,060,356
Total	128,310,023	124,972,818	119,751,946
Total Operating Expenses:			
Regulated Services	109,027,757	106,346,702	105,796,706
Total	113,563,000	109,684,000	108,754,924
Net Operating Profit (Loss):			
Regulated Services	18,012,966	17,413,251	12,894,884
Unregulated Services	-3,265,943	-2,124,433	-1,897,862
Total	14,747,023	15,288,818	10,997,022
Total Non-Operating Profit (Loss):	-1,187,000	-1,005,000	-828,000
Non-Operating Revenue	408,000	-1,005,000	-1,009,000
Non-Operating Expenses	1,595,000	0	-181,000
Total Excess Profit (Loss):	13,560,023	14,283,818	10,169,022
% Net Operating Profit of Regulated NOR	14.18	14.07	10.86
% Net Total Operating Profit of Total NOR	11.49	12.23	9.18
% Total Excess Profit of Total Revenue	10.53	11.52	8.56
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	10,730,727	11,854,863	11,779,052
Risk Adjusted Readmission Percent:	9.98%	11.95%	11.70%
Potentially Avoidable Utilization Costs:	20,981,683	22,907,807	23,174,274
Risk Adjusted PPC Rate:	0.79	0.77	0.83

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-HARFORD MEMORIAL HOSPITAL

FISCAL YEAR ENDING	June 2016	June 2015	December 2013
Gross Patient Revenue:			
Regulated Services	104,106,100	104,703,700	103,499,300
Unregulated Services	220,000	156,000	130,700
TOTAL	104,326,100	104,859,700	103,630,000
Net Patient Revenue (NPR):			
Regulated Services	89,067,100	86,689,400	80,749,039
Unregulated Services	220,000	91,600	61,300
TOTAL	89,287,100	86,781,000	80,810,339
Other Operating Revenue:			
Regulated Services	633,667	1,453,800	2,452,600
Unregulated Services	313,191	661,900	479,400
TOTAL	946,858	2,115,700	2,932,000
Net Operating Revenue (NOR)			
Regulated Services	89,700,767	88,143,200	83,201,639
Unregulated Services	533,191	753,500	540,700
Total	90,233,958	88,896,700	83,742,339
Total Operating Expenses:			
Regulated Services	80,295,000	77,762,696	77,131,271
Total	82,723,000	79,992,100	79,558,000
Net Operating Profit (Loss):			
Regulated Services	9,405,767	10,380,504	6,070,368
Unregulated Services	-1,894,809	-1,475,904	-1,886,029
Total	7,510,958	8,904,600	4,184,339
Total Non-Operating Profit (Loss):	490,000	501,000	7,340,000
Non-Operating Revenue	490,000	4,800,000	7,340,000
Non-Operating Expenses	0	4,299,000	0
Total Excess Profit (Loss):	8,000,958	9,405,600	11,524,339
% Net Operating Profit of Regulated NOR	10.49	11.78	7.30
% Net Total Operating Profit of Total NOR	8.32	10.02	5.00
% Total Excess Profit of Total Revenue	8.82	10.04	12.65
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	10,400,564	9,729,882	9,505,802
Risk Adjusted Readmission Percent:	11.37%	10.46%	11.79%
Potentially Avoidable Utilization Costs:	18,317,616	17,713,148	17,064,455
Risk Adjusted PPC Rate:	0.63	0.90	1.23

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-QUEEN ANNE'S FREESTANDING EMERGENCY CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	6,243,200	4,794,500	5,190,800
Unregulated Services	0	0	0
TOTAL	6,243,200	4,794,500	5,190,800
Net Patient Revenue (NPR):			
Regulated Services	4,951,239	4,322,561	4,257,207
Unregulated Services	0	0	0
TOTAL	4,951,239	4,322,561	4,257,207
Other Operating Revenue:			
Regulated Services	5,780	5,799	9,569
Unregulated Services	0	0	0
TOTAL	5,780	5,799	9,569
Net Operating Revenue (NOR)			
Regulated Services	4,957,019	4,328,360	4,266,776
Unregulated Services	0	0	0
Total	4,957,019	4,328,360	4,266,776
Total Operating Expenses:			
Regulated Services	6,871,442	7,275,580	7,584,616
Total	6,871,442	7,290,680	7,584,616
Net Operating Profit (Loss):			
Regulated Services	-1,914,423	-2,947,220	-3,317,840
Unregulated Services	0	-15,100	0
Total	-1,914,423	-2,962,320	-3,317,840
Total Non-Operating Profit (Loss):	-44,000	6,253	-29,398
Non-Operating Revenue	0	6,253	-29,398
Non-Operating Expenses	44,000	0	0
Total Excess Profit (Loss):	-1,958,423	-2,956,067	-3,347,238
% Net Operating Profit of Regulated NOR	-38.62	-68.09	-77.76
% Net Total Operating Profit of Total NOR	-38.62	-68.44	-77.76
% Total Excess Profit of Total Revenue	-39.51	-68.20	-78.99
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	0	0	0
Risk Adjusted Readmission Percent:	0.00%	0.00%	0.00%
Potentially Avoidable Utilization Costs:	0	0	0
Risk Adjusted PPC Rate:	0.00	0.00	0.00

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-REHABILITATION & ORTHOPAEDIC INSTITUTE

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	118,766,800	120,364,600	118,262,200
Unregulated Services	1,084,001	1,043,037	1,205,991
TOTAL	119,850,801	121,407,637	119,468,191
Net Patient Revenue (NPR):			
Regulated Services	100,742,920	101,157,600	98,687,200
Unregulated Services	677,001	573,037	611,991
TOTAL	101,419,921	101,730,637	99,299,191
Other Operating Revenue:			
Regulated Services	3,971,892	2,453,297	2,099,610
Unregulated Services	1,747,108	1,917,058	1,870,812
TOTAL	5,719,000	4,370,355	3,970,422
Net Operating Revenue (NOR)			
Regulated Services	104,714,812	103,610,897	100,786,810
Unregulated Services	2,424,109	2,490,095	2,482,803
Total	107,138,921	106,100,992	103,269,613
Total Operating Expenses:			
Regulated Services	100,941,425	102,984,560	99,422,003
Total	103,856,400	106,210,000	102,736,500
Net Operating Profit (Loss):			
Regulated Services	3,773,387	626,337	1,364,808
Unregulated Services	-490,867	-735,345	-831,695
Total	3,282,521	-109,008	533,113
Total Non-Operating Profit (Loss):	-1,057,000	-524,000	1,269,000
Non-Operating Revenue	-1,057,000	-524,000	1,269,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	2,225,521	-633,008	1,802,113
% Net Operating Profit of Regulated NOR	3.60	0.60	1.35
% Net Total Operating Profit of Total NOR	3.06	-0.10	0.52
% Total Excess Profit of Total Revenue	2.10	-0.60	1.72
Total Direct Medical Education:	4,088,269	4,287,880	4,767,170
Inpatient Readmission Charges:	299,256	402,445	555,055
Risk Adjusted Readmission Percent:	9.82%	8.59%	8.36%
Potentially Avoidable Utilization Costs:	299,256	402,445	555,055
Risk Adjusted PPC Rate:	0.86	0.78	1.09

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-SHOCK TRAUMA

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	202,325,400	197,941,300	202,364,100
Unregulated Services	4,442,063	5,318,329	5,165,260
TOTAL	206,767,463	203,259,629	207,529,360
Net Patient Revenue (NPR):			
Regulated Services	173,816,937	169,890,126	166,218,825
Unregulated Services	4,442,063	5,318,329	5,165,260
TOTAL	178,259,000	175,208,455	171,384,085
Other Operating Revenue:			
Regulated Services	3,378,000	3,375,000	3,126,000
Unregulated Services	0	0	0
TOTAL	3,378,000	3,375,000	3,126,000
Net Operating Revenue (NOR)			
Regulated Services	177,194,937	173,265,126	169,344,825
Unregulated Services	4,442,063	5,318,329	5,165,260
Total	181,637,000	178,583,455	174,510,085
Total Operating Expenses:			
Regulated Services	159,078,900	155,366,237	149,776,000
Total	162,363,000	160,789,537	155,394,000
Net Operating Profit (Loss):			
Regulated Services	18,116,037	17,898,888	19,568,825
Unregulated Services	1,157,963	-104,971	-452,740
Total	19,274,000	17,793,917	19,116,085
Total Non-Operating Profit (Loss):	1,500,000	1,500,000	1,500,000
Non-Operating Revenue	1,500,000	1,500,000	900,000
Non-Operating Expenses	0	0	-600,000
Total Excess Profit (Loss):	20,774,000	19,293,917	20,616,085
% Net Operating Profit of Regulated NOR	10.22	10.33	11.56
% Net Total Operating Profit of Total NOR	10.61	9.96	10.95
% Total Excess Profit of Total Revenue	11.34	10.71	11.75
Total Direct Medical Education:	11,303,486	8,483,190	9,619,796
Inpatient Readmission Charges:	0	0	0
Risk Adjusted Readmission Percent:	0.00%	0.00%	0.00%
Potentially Avoidable Utilization Costs:	0	0	0
Risk Adjusted PPC Rate:	0.00	0.00	0.00

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-SHORE REGIONAL HEALTH AT CHESTERTOWN

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	60,065,200	64,477,400	64,508,977
Unregulated Services	4,040,268	3,756,475	3,555,824
TOTAL	64,105,468	68,233,875	68,064,801
Net Patient Revenue (NPR):			
Regulated Services	49,733,012	46,873,264	49,270,622
Unregulated Services	3,848,356	3,571,140	3,379,824
TOTAL	53,581,368	50,444,404	52,650,446
Other Operating Revenue:			
Regulated Services	-236,735	32,274	53,666
Unregulated Services	217,267	226,834	230,078
TOTAL	-19,468	259,108	283,744
Net Operating Revenue (NOR)			
Regulated Services	49,496,277	46,905,538	49,324,288
Unregulated Services	4,065,623	3,797,974	3,609,902
Total	53,561,900	50,703,512	52,934,190
Total Operating Expenses:			
Regulated Services	42,567,673	43,026,022	40,990,213
Total	48,612,000	49,362,348	47,353,897
Net Operating Profit (Loss):			
Regulated Services	6,928,604	3,879,516	8,334,074
Unregulated Services	-1,978,704	-2,538,352	-2,753,782
Total	4,949,900	1,341,164	5,580,293
Total Non-Operating Profit (Loss):	-403,000	-166,984	969,715
Non-Operating Revenue	390,000	-162,293	1,041,405
Non-Operating Expenses	793,000	4,691	71,690
Total Excess Profit (Loss):	4,546,900	1,174,180	6,550,008
% Net Operating Profit of Regulated NOR	14.00	8.27	16.90
% Net Total Operating Profit of Total NOR	9.24	2.65	10.54
% Total Excess Profit of Total Revenue	8.43	2.32	12.14
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	3,603,074	3,588,646	5,039,107
Risk Adjusted Readmission Percent:	13.05%	11.18%	12.70%
Potentially Avoidable Utilization Costs:	8,030,371	8,842,085	10,081,111
Risk Adjusted PPC Rate:	0.96	1.10	0.70

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-SHORE REGIONAL HEALTH AT DORCHESTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	51,452,800	56,007,200	58,994,300
Unregulated Services	2,871,072	3,201,167	3,348,901
TOTAL	54,323,872	59,208,367	62,343,201
Net Patient Revenue (NPR):			
Regulated Services	42,352,628	43,898,251	44,745,961
Unregulated Services	1,601,672	1,107,367	950,026
TOTAL	43,954,300	45,005,618	45,695,987
Other Operating Revenue:			
Regulated Services	48,433	43,602	144,703
Unregulated Services	278,833	263,178	269,579
TOTAL	327,266	306,780	414,282
Net Operating Revenue (NOR)			
Regulated Services	42,401,061	43,941,853	44,890,664
Unregulated Services	1,880,505	1,370,545	1,219,605
Total	44,281,566	45,312,398	46,110,269
Total Operating Expenses:			
Regulated Services	36,427,923	35,650,610	36,608,786
Total	39,379,514	38,814,754	39,673,868
Net Operating Profit (Loss):			
Regulated Services	5,973,138	8,291,243	8,281,878
Unregulated Services	-1,071,086	-1,793,599	-1,845,477
Total	4,902,052	6,497,644	6,436,401
Total Non-Operating Profit (Loss):	-322,815	45,254	-211,918
Non-Operating Revenue	-322,815	45,254	-211,918
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	4,579,237	6,542,898	6,224,482
% Net Operating Profit of Regulated NOR	14.09	18.87	18.45
% Net Total Operating Profit of Total NOR	11.07	14.34	13.96
% Total Excess Profit of Total Revenue	10.42	14.43	13.56
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	4,535,879	6,108,177	4,549,403
Risk Adjusted Readmission Percent:	10.97%	12.08%	10.70%
Potentially Avoidable Utilization Costs:	9,865,050	12,359,041	11,328,430
Risk Adjusted PPC Rate:	0.68	1.03	1.17

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-SHORE REGIONAL HEALTH AT EASTON

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	199,614,100	192,831,500	187,483,400
Unregulated Services	45,475,282	45,431,600	43,572,553
TOTAL	245,089,382	238,263,100	231,055,953
Net Patient Revenue (NPR):			
Regulated Services	172,262,074	163,132,861	152,823,340
Unregulated Services	17,354,162	15,693,215	14,648,824
TOTAL	189,616,236	178,826,076	167,472,165
Other Operating Revenue:			
Regulated Services	369,942	691,214	814,178
Unregulated Services	2,054,649	2,241,300	1,841,348
TOTAL	2,424,591	2,932,514	2,655,526
Net Operating Revenue (NOR)			
Regulated Services	172,632,016	163,824,075	153,637,519
Unregulated Services	19,408,811	17,934,515	16,490,172
Total	192,040,827	181,758,590	170,127,691
Total Operating Expenses:			
Regulated Services	146,753,345	140,456,749	140,191,581
Total	168,978,020	161,959,446	160,828,827
Net Operating Profit (Loss):			
Regulated Services	25,878,671	23,367,326	13,445,938
Unregulated Services	-2,815,864	-3,568,182	-4,147,074
Total	23,062,807	19,799,144	9,298,864
Total Non-Operating Profit (Loss):	-3,721,000	-296,359	7,882,051
Non-Operating Revenue	3,787,000	-296,359	7,882,051
Non-Operating Expenses	7,508,000	0	0
Total Excess Profit (Loss):	19,341,807	19,502,785	17,180,916
% Net Operating Profit of Regulated NOR	14.99	14.26	8.75
% Net Total Operating Profit of Total NOR	12.01	10.89	5.47
% Total Excess Profit of Total Revenue	9.88	10.75	9.65
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	11,213,488	11,130,133	11,005,227
Risk Adjusted Readmission Percent:	11.29%	11.53%	11.40%
Potentially Avoidable Utilization Costs:	23,304,173	23,250,889	22,102,453
Risk Adjusted PPC Rate:	0.67	1.08	1.12

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-ST. JOSEPH MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	402,082,700	390,826,300	362,415,700
Unregulated Services	2,818,692	3,044,464	3,646,000
TOTAL	404,901,392	393,870,764	366,061,700
Net Patient Revenue (NPR):			
Regulated Services	345,943,269	323,889,336	295,642,876
Unregulated Services	2,677,731	2,849,664	3,416,124
TOTAL	348,621,000	326,739,000	299,059,000
Other Operating Revenue:			
Regulated Services	415,243	503,132	386,513
Unregulated Services	2,921,010	2,623,868	2,769,487
TOTAL	3,336,252	3,127,000	3,156,000
Net Operating Revenue (NOR)			
Regulated Services	346,358,512	324,392,467	296,029,390
Unregulated Services	5,598,741	5,473,533	6,185,610
Total	351,957,252	329,866,000	302,215,000
Total Operating Expenses:			
Regulated Services	301,275,913	294,947,644	288,289,144
Total	325,630,352	319,343,921	310,933,000
Net Operating Profit (Loss):			
Regulated Services	45,082,599	29,444,823	7,740,245
Unregulated Services	-18,755,699	-18,922,744	-16,458,245
Total	26,326,900	10,522,079	-8,718,000
Total Non-Operating Profit (Loss):	-3,502,000	-2,797,000	-5,413,000
Non-Operating Revenue	0	0	1,897,000
Non-Operating Expenses	3,502,000	2,797,000	7,310,000
Total Excess Profit (Loss):	22,824,900	7,725,079	-14,131,000
% Net Operating Profit of Regulated NOR	13.02	9.08	2.61
% Net Total Operating Profit of Total NOR	7.48	3.19	-2.88
% Total Excess Profit of Total Revenue	6.49	2.34	-4.65
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	20,983,083	21,550,484	18,552,314
Risk Adjusted Readmission Percent:	10.60%	11.28%	11.22%
Potentially Avoidable Utilization Costs:	33,240,517	32,877,337	28,822,886
Risk Adjusted PPC Rate:	0.70	0.90	1.10

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UM-UPPER CHESAPEAKE MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	December 2013
Gross Patient Revenue:			
Regulated Services	330,967,000	320,267,600	290,000,800
Unregulated Services	986,000	1,089,734	226,600
TOTAL	331,953,000	321,357,334	290,227,400
Net Patient Revenue (NPR):			
Regulated Services	284,816,000	268,193,832	241,546,300
Unregulated Services	986,000	1,089,734	121,000
TOTAL	285,802,000	269,283,566	241,667,300
Other Operating Revenue:			
Regulated Services	3,449,774	6,358,000	2,938,400
Unregulated Services	1,170,199	0	2,642,600
TOTAL	4,619,972	6,358,000	5,581,000
Net Operating Revenue (NOR)			
Regulated Services	288,265,774	274,551,832	244,484,700
Unregulated Services	2,156,199	1,089,734	2,763,600
Total	290,421,972	275,641,566	247,248,300
Total Operating Expenses:			
Regulated Services	248,188,841	231,433,257	220,046,741
Total	261,076,000	241,611,000	228,970,300
Net Operating Profit (Loss):			
Regulated Services	40,076,933	43,118,575	24,437,959
Unregulated Services	-10,730,960	-9,088,009	-6,159,959
Total	29,345,972	34,030,566	18,278,000
Total Non-Operating Profit (Loss):	790,000	-10,687,000	4,122,000
Non-Operating Revenue	4,526,000	329,000	4,122,000
Non-Operating Expenses	3,736,000	11,016,000	0
Total Excess Profit (Loss):	30,135,972	23,343,566	22,400,000
% Net Operating Profit of Regulated NOR	13.90	15.71	10.00
% Net Total Operating Profit of Total NOR	10.10	12.35	7.39
% Total Excess Profit of Total Revenue	10.22	8.46	8.91
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	20,737,781	21,988,096	21,705,826
Risk Adjusted Readmission Percent:	11.21%	11.84%	11.70%
Potentially Avoidable Utilization Costs:	36,338,280	37,846,064	37,090,133
Risk Adjusted PPC Rate:	0.67	0.72	1.04

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UMMC MIDTOWN CAMPUS

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	226,817,000	228,795,700	222,427,600
Unregulated Services	5,604,180	15,788,605	15,808,226
TOTAL	232,421,180	244,584,305	238,235,826
Net Patient Revenue (NPR):			
Regulated Services	187,121,556	185,184,700	174,389,612
Unregulated Services	5,038,625	6,810,964	5,994,896
TOTAL	192,160,180	191,995,664	180,384,509
Other Operating Revenue:			
Regulated Services	-281,532	471,695	1,163,270
Unregulated Services	1,108,352	1,066,278	998,502
TOTAL	826,820	1,537,973	2,161,772
Net Operating Revenue (NOR)			
Regulated Services	186,840,024	185,656,395	175,552,882
Unregulated Services	6,146,976	7,877,242	6,993,398
Total	192,987,000	193,533,638	182,546,280
Total Operating Expenses:			
Regulated Services	162,862,836	162,177,865	152,556,172
Total	191,264,500	192,081,025	178,869,079
Net Operating Profit (Loss):			
Regulated Services	23,977,188	23,478,530	22,996,711
Unregulated Services	-22,254,688	-22,025,917	-19,319,509
Total	1,722,500	1,452,613	3,677,202
Total Non-Operating Profit (Loss):	-544,000	-509,000	-599,000
Non-Operating Revenue	-544,000	-509,000	-599,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	1,178,500	943,613	3,078,202
% Net Operating Profit of Regulated NOR	12.83	12.65	13.10
% Net Total Operating Profit of Total NOR	0.89	0.75	2.01
% Total Excess Profit of Total Revenue	0.61	0.49	1.69
Total Direct Medical Education:	3,073,957	4,028,360	4,245,770
Inpatient Readmission Charges:	23,378,868	26,229,348	26,651,282
Risk Adjusted Readmission Percent:	15.17%	15.49%	16.42%
Potentially Avoidable Utilization Costs:	31,651,947	34,466,776	33,953,129
Risk Adjusted PPC Rate:	0.30	1.05	0.88

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UNION HOSPITAL OF CECIL COUNTY

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	160,304,000	157,025,000	157,913,800
Unregulated Services	37,385,100	36,162,400	31,936,900
TOTAL	197,689,100	193,187,400	189,850,700
Net Patient Revenue (NPR):			
Regulated Services	136,329,669	132,874,783	130,347,100
Unregulated Services	15,817,800	16,574,100	14,803,200
TOTAL	152,147,469	149,448,883	145,150,300
Other Operating Revenue:			
Regulated Services	1,469,400	1,927,000	2,557,500
Unregulated Services	2,144,800	2,003,400	2,080,699
TOTAL	3,614,200	3,930,400	4,638,199
Net Operating Revenue (NOR)			
Regulated Services	137,799,069	134,801,783	132,904,600
Unregulated Services	17,962,600	18,577,500	16,883,899
Total	155,761,669	153,379,283	149,788,499
Total Operating Expenses:			
Regulated Services	121,512,400	120,149,000	117,995,300
Total	152,643,900	150,750,000	146,416,200
Net Operating Profit (Loss):			
Regulated Services	16,286,669	14,652,783	14,909,300
Unregulated Services	-13,168,900	-12,023,500	-11,537,000
Total	3,117,769	2,629,283	3,372,300
Total Non-Operating Profit (Loss):	-257,800	-466,100	7,438,200
Non-Operating Revenue	35,000	596,700	7,725,300
Non-Operating Expenses	292,800	1,062,800	287,100
Total Excess Profit (Loss):	2,859,969	2,163,183	10,810,500
% Net Operating Profit of Regulated NOR	11.82	10.87	11.22
% Net Total Operating Profit of Total NOR	2.00	1.71	2.25
% Total Excess Profit of Total Revenue	1.84	1.40	6.86
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	9,298,988	10,520,633	9,233,707
Risk Adjusted Readmission Percent:	10.81%	11.07%	9.77%
Potentially Avoidable Utilization Costs:	19,959,860	20,898,413	16,863,250
Risk Adjusted PPC Rate:	0.60	0.83	1.04

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

UNIVERSITY OF MARYLAND MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	1,345,458,400	1,313,670,900	1,296,211,400
Unregulated Services	11,821,641	11,691,229	10,519,886
TOTAL	1,357,280,041	1,325,362,129	1,306,731,286
Net Patient Revenue (NPR):			
Regulated Services	1,173,234,222	1,124,828,668	1,086,670,121
Unregulated Services	11,453,778	11,167,335	10,407,916
TOTAL	1,184,688,000	1,135,996,003	1,097,078,037
Other Operating Revenue:			
Regulated Services	17,699,437	24,332,274	18,824,460
Unregulated Services	101,319,563	77,095,726	50,534,530
TOTAL	119,019,000	101,428,000	69,358,990
Net Operating Revenue (NOR)			
Regulated Services	1,190,933,659	1,149,160,942	1,105,494,581
Unregulated Services	112,773,341	88,263,061	60,942,446
Total	1,303,707,000	1,237,424,003	1,166,437,027
Total Operating Expenses:			
Regulated Services	1,159,018,353	1,100,361,772	1,060,074,815
Total	1,283,342,000	1,201,701,000	1,142,114,001
Net Operating Profit (Loss):			
Regulated Services	31,915,307	48,799,170	45,419,769
Unregulated Services	-11,550,307	-13,076,167	-21,096,733
Total	20,365,000	35,723,003	24,323,036
Total Non-Operating Profit (Loss):	-71,817,000	-41,947,000	149,439,000
Non-Operating Revenue	-71,817,000	-41,947,000	149,439,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-51,452,000	-6,223,997	173,762,036
% Net Operating Profit of Regulated NOR	2.68	4.25	4.11
% Net Total Operating Profit of Total NOR	1.56	2.89	2.09
% Total Excess Profit of Total Revenue	-4.18	-0.52	13.21
Total Direct Medical Education:	104,524,509	82,832,410	81,820,610
Inpatient Readmission Charges:	96,218,670	97,043,693	101,973,000
Risk Adjusted Readmission Percent:	12.92%	13.44%	14.63%
Potentially Avoidable Utilization Costs:	119,384,117	123,572,331	125,818,563
Risk Adjusted PPC Rate:	0.66	0.86	1.14

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

WASHINGTON ADVENTIST HOSPITAL

FISCAL YEAR ENDING	December 2015	December 2014	December 2013
Gross Patient Revenue:			
Regulated Services	260,621,900	260,306,100	245,900,400
Unregulated Services	0	3,791	23,951
TOTAL	260,621,900	260,309,891	245,924,351
Net Patient Revenue (NPR):			
Regulated Services	222,422,118	209,906,016	196,111,014
Unregulated Services	0	3,791	23,399
TOTAL	222,422,118	209,909,807	196,134,413
Other Operating Revenue:			
Regulated Services	1,625,794	1,378,906	3,888,835
Unregulated Services	3,556,908	3,547,691	2,651,790
TOTAL	5,182,702	4,926,597	6,540,625
Net Operating Revenue (NOR)			
Regulated Services	224,047,912	211,284,922	199,999,849
Unregulated Services	3,556,908	3,551,482	2,675,189
Total	227,604,820	214,836,404	202,675,038
Total Operating Expenses:			
Regulated Services	202,140,053	194,645,259	199,029,900
Total	217,955,646	210,709,734	213,396,004
Net Operating Profit (Loss):			
Regulated Services	21,907,859	16,639,663	969,949
Unregulated Services	-12,258,685	-12,512,993	-11,690,915
Total	9,649,174	4,126,670	-10,720,966
Total Non-Operating Profit (Loss):	-1,216,081	-1,500,747	-1,509,711
Non-Operating Revenue	-1,216,081	-1,500,747	-1,509,711
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	8,433,093	2,625,923	-12,230,677
% Net Operating Profit of Regulated NOR	9.78	7.88	0.48
% Net Total Operating Profit of Total NOR	4.24	1.92	-5.29
% Total Excess Profit of Total Revenue	3.73	1.23	-6.08
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	20,351,493	22,026,338	20,954,891
Risk Adjusted Readmission Percent:	10.64%	11.99%	11.47%
Potentially Avoidable Utilization Costs:	32,737,935	35,157,850	36,649,317
Risk Adjusted PPC Rate:	1.00	1.10	1.09

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014 TO 2016

WESTERN MARYLAND REGIONAL MEDICAL CENTER

FISCAL YEAR ENDING	June 2016	June 2015	June 2014
Gross Patient Revenue:			
Regulated Services	325,608,000	322,958,900	317,898,800
Unregulated Services	73,613,400	68,884,200	62,831,500
TOTAL	399,221,400	391,843,100	380,730,300
Net Patient Revenue (NPR):			
Regulated Services	268,769,800	262,636,400	255,447,200
Unregulated Services	43,776,800	42,475,800	37,907,800
TOTAL	312,546,600	305,112,200	293,355,000
Other Operating Revenue:			
Regulated Services	4,372,600	3,966,600	5,313,699
Unregulated Services	2,247,800	2,512,300	2,673,100
TOTAL	6,620,400	6,478,900	7,986,799
Net Operating Revenue (NOR)			
Regulated Services	273,142,400	266,603,000	260,760,899
Unregulated Services	46,024,600	44,988,100	40,580,900
Total	319,167,000	311,591,100	301,341,799
Total Operating Expenses:			
Regulated Services	237,078,721	225,634,304	221,999,899
Total	313,183,200	289,953,900	281,594,900
Net Operating Profit (Loss):			
Regulated Services	36,063,679	40,968,696	38,761,001
Unregulated Services	-30,079,879	-19,331,496	-19,014,101
Total	5,983,800	21,637,200	19,746,900
Total Non-Operating Profit (Loss):	1,976,900	-450,600	5,514,799
Non-Operating Revenue	1,976,900	-450,600	5,514,799
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	7,960,700	21,186,600	25,261,700
% Net Operating Profit of Regulated NOR	13.20	15.37	14.86
% Net Total Operating Profit of Total NOR	1.87	6.94	6.55
% Total Excess Profit of Total Revenue	2.48	6.81	8.23
Total Direct Medical Education:	0	0	0
Inpatient Readmission Charges:	20,237,167	21,068,604	18,787,465
Risk Adjusted Readmission Percent:	10.96%	12.23%	11.86%
Potentially Avoidable Utilization Costs:	34,135,511	36,268,949	32,532,068
Risk Adjusted PPC Rate:	0.87	1.00	0.94

DETAILS OF THE DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA: SPECIALTY HOSPITALS

ALL SPECIALTY HOSPITALS

Year Ending	FY 2016	FY 2015	FY 2014
Gross Patient Revenue	360,503,950	350,995,883	330,633,889
Net Patient Revenue (NPR)	286,784,598	274,488,326	260,261,213
Other Operating Revenue	110,690,954	103,990,946	101,390,755
Net Operating Revenue (NOR)	397,475,552	378,479,272	361,651,968
Operating Expenses	376,333,665	358,955,776	342,320,127
Inpatient Admissions (IPAs)	16,756	16,781	16,161
Net Operating Profit (Loss)	21,141,887	19,523,496	19,331,841
Total Non-Operating Profit (Loss)	2,070,317	4,168,263	9,900,231
Total Excess Profits (Loss)	23,212,204	23,691,759	29,232,072

Adventist Behavioral Health-Rockville

Year Ending	CY 2015	CY 2014	CY 2013
Gross Patient Revenue	45,589,500	50,079,100	43,256,200
Net Patient Revenue (NPR)	37,529,900	42,020,400	37,576,300
Other Operating Revenue	7,274,900	6,435,200	6,829,600
Net Operating Revenue (NOR)	44,804,800	48,455,600	44,405,900
Operating Expenses	44,456,400	43,380,600	42,158,200
Inpatient Admissions (IPAs)	2,627	2,949	2,705
Net Operating Profit (Loss)	348,400	5,075,000	2,247,700
Total Non-Operating Profit (Loss)	(78,800)	(150,200)	(197,200)
Total Excess Profits (Loss)	269,600	4,924,800	2,050,500

Adventist Rehab Hospital of MD.

Year Ending	CY 2015	CY 2014	CY 2013
Gross Patient Revenue	68,932,729	63,183,083	59,348,989
Net Patient Revenue (NPR)	40,331,779	31,243,964	32,969,459
Other Operating Revenue	442,854	393,446	360,155
Net Operating Revenue (NOR)	40,774,633	31,637,410	33,329,614
Operating Expenses	38,791,987	34,784,403	33,160,136
Inpatient Admissions (IPAs)	1,941	1,801	1,574
Net Operating Profit (Loss)	1,982,646	(3,146,993)	169,478
Total Non-Operating Profit (Loss)	(23,783)	103,663	46,531
Total Excess Profits (Loss)	1,958,863	(3,043,330)	216,009

Brook Lane Health Services

Year Ending	FY 2016	FY 2015	FY 2014
Gross Patient Revenue	30,539,800	25,350,400	21,848,000
Net Patient Revenue (NPR)	23,993,000	20,295,000	17,220,300
Other Operating Revenue	7,098,400	6,153,900	5,630,700
Net Operating Revenue (NOR)	31,091,400	26,448,900	22,851,000
Operating Expenses	29,513,500	25,579,000	22,498,700
Inpatient Admissions (IPAs)	2,033	1,770	1,677
Net Operating Profit (Loss)	1,577,900	869,900	352,300
Total Non-Operating Profit (Loss)	128,400	1,284,600	(41,200)
Total Excess Profits (Loss)	1,706,300	2,154,500	311,100

Adventist Behavioral Health - Eastern Shore

Year Ending	CY 2015	CY 2014	CY 2013
Gross Patient Revenue	3,245,821	2,409,200	2,508,000
Net Patient Revenue (NPR)	2,780,319	1,896,662	2,045,654
Other Operating Revenue	0	0	0
Net Operating Revenue (NOR)	2,780,319	1,896,662	2,045,654
Operating Expenses	795,278	576,673	616,191
Inpatient Admissions (IPAs)	302	297	271
Net Operating Profit (Loss)	1,985,041	1,319,989	1,429,463
Total Non-Operating Profit (Loss)	0	0	0
Total Excess Profits (Loss)	1,985,041	1,319,989	1,429,463

Mt. Washington Pediatric Hospital

Year Ending	FY 2016	FY 2015	FY 2014
Gross Patient Revenue	66,639,000	68,191,600	63,497,200
Net Patient Revenue (NPR)	56,409,800	57,966,400	53,041,000
Other Operating Revenue	1,068,600	1,164,800	1,356,700
Net Operating Revenue (NOR)	57,478,400	59,131,200	54,397,700
Operating Expenses	53,852,000	53,819,900	50,042,300
Inpatient Admissions (IPAs)	761	813	795
Net Operating Profit (Loss)	3,626,400	5,311,300	4,355,400
Total Non-Operating Profit (Loss)	(55,900)	55,100	4,034,000
Total Excess Profits (Loss)	3,570,500	5,366,400	8,389,400

Sheppard Pratt Hospital

Year Ending	FY 2016	FY 2015	FY 2014
Gross Patient Revenue	145,557,100	141,782,500	140,175,500
Net Patient Revenue (NPR)	125,739,800	121,065,900	117,408,500
Other Operating Revenue	94,806,200	89,843,600	87,213,600
Net Operating Revenue (NOR)	220,546,000	210,909,500	204,622,100
Operating Expenses	208,924,500	200,815,200	193,844,600
Inpatient Admissions (IPAs)	9,092	9,151	9,139
Net Operating Profit (Loss)	11,621,500	10,094,300	10,777,500
Total Non-Operating Profit (Loss)	2,100,400	2,875,100	6,058,100
Total Excess Profits (Loss)	13,721,900	12,969,400	16,835,600

EXHIBIT I-A. CHANGE IN UNCOMPENSATED CARE, REGULATED OPERATIONS

		2015			2016			
Hospital Area	Hospital	Gross Revenues	Charity & Bad Debts	UCC %	Gross Revenues	Charity & Bad Debts	UCC %	% Change UCC Amount
M E T R O	ANNE ARUNDEL MEDICAL CENTER	562,952,500	17,108,400	3.04	576,313,300	14,649,098	2.54	-14.4
	BON SECOURS HOSPITAL	117,217,800	4,640,014	3.96	106,732,300	3,965,309	3.72	-14.5
	BOWIE EMERGENCY CENTER	20,111,300	3,395,072	16.88	20,228,300	5,464,725	27.02	61.0
	DOCTORS COMMUNITY HOSPITAL	226,462,500	16,475,191	7.28	234,045,500	17,202,246	7.35	4.4
	FORT WASHINGTON MEDICAL CENTER	48,565,970	5,271,258	10.85	48,291,192	4,215,392	8.73	-20.0
	GERMANTOWN EMERGENCY CENTER	14,059,900	2,928,631	20.83	13,555,000	2,998,458	22.12	2.4
	GREATER BALTIMORE MEDICAL CENTER	432,707,700	10,736,746	2.48	439,684,200	11,490,159	2.61	7.0
	HOLY CROSS HOSPITAL	480,562,300	38,696,900	8.05	505,712,400	45,443,000	8.99	17.4
	HOLY CROSS HOSPITAL-GERMANTOWN	43,305,400	4,143,200	9.57	80,883,300	8,061,600	9.97	94.6
	HOWARD COUNTY GENERAL HOSPITAL	286,302,800	11,859,000	4.14	297,946,200	9,809,000	3.29	-17.3
	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	618,220,800	40,097,000	6.49	643,455,400	32,847,000	5.10	-18.1
	JOHNS HOPKINS HOSPITAL	2,209,868,500	49,710,100	2.25	2,282,683,400	47,821,500	2.09	-3.8
	LAUREL REGIONAL HOSPITAL	106,467,900	9,376,744	8.81	106,117,500	12,313,260	11.60	31.3
	LEVINDALE	59,785,479	2,454,993	4.11	60,312,800	2,615,214	4.34	6.5
	MEDSTAR FRANKLIN SQUARE	491,172,800	20,158,582	4.10	505,736,100	22,427,068	4.43	11.3
	MEDSTAR GOOD SAMARITAN	303,789,300	12,198,847	4.02	289,108,800	14,558,603	5.04	19.3
	MEDSTAR HARBOR HOSPITAL CENTER	207,452,600	10,376,136	5.00	194,368,900	11,195,426	5.76	7.9
	MEDSTAR MONTGOMERY MEDICAL CENTER	174,302,200	8,301,281	4.76	175,827,977	7,101,577	4.04	-14.5
	MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	262,672,600	15,033,744	5.72	271,938,700	16,181,442	5.95	7.6

CHANGE IN UNCOMPENSATED CARE (UCC): EXHIBIT I-A
REGULATED OPERATIONS
Listed in Alphabetical Order by Region

		2015			2016			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
	MEDSTAR UNION MEMORIAL HOSPITAL	419,374,600	14,810,320	3.53	426,343,800	18,071,382	4.24	22.0
	MERCY MEDICAL CENTER	495,805,900	31,935,790	6.44	513,599,600	27,253,260	5.31	-14.7
	NORTHWEST HOSPITAL CENTER	254,115,900	15,937,500	6.27	257,944,700	14,575,617	5.65	-8.5
	PRINCE GEORGES HOSPITAL CENTER	279,091,000	25,794,211	9.24	285,682,600	27,058,517	9.47	4.9
	SHADY GROVE ADVENTIST HOSPITAL	383,323,300	29,442,581	7.68	389,913,200	18,664,288	4.79	-36.6
	SINAI HOSPITAL	717,312,400	30,113,400	4.20	732,671,600	28,586,943	3.90	-5.1
	ST. AGNES HOSPITAL	418,876,800	20,902,206	4.99	432,204,400	24,889,102	5.76	19.1
	SUBURBAN HOSPITAL	295,844,600	11,753,155	3.97	301,899,200	6,213,087	2.06	-47.1
	UM-BALTIMORE WASHINGTON MEDICAL CENTER	402,010,800	23,399,564	5.82	413,064,200	23,239,033	5.63	-0.7
	UM-QUEEN ANNE'S FREESTANDING EMERGENCY	4,794,500	255,761	5.33	6,243,200	715,309	11.46	179.7
	UM-REHABILITATION & ORTHOPAEDIC INSTIT	120,364,600	5,640,901	4.69	118,766,800	7,254,441	6.11	28.6
	UM-SHOCK TRAUMA	197,941,300	24,974,663	12.62	202,325,400	12,183,975	6.02	-51.2
	UM-ST. JOSEPH MEDICAL CENTER	390,826,300	15,978,200	4.09	402,082,700	16,456,039	4.09	3.0
	UM-UPPER CHESAPEAKE MEDICAL CENTER	320,267,600	16,806,953	5.25	330,967,000	11,900,000	3.60	-29.2
	UMMC MIDTOWN CAMPUS	228,795,700	24,054,357	10.51	226,817,000	18,527,678	8.17	-23.0
	UNIVERSITY OF MARYLAND MEDICAL CENTER	1,313,670,900	36,135,103	2.75	1,345,458,400	54,173,072	4.03	49.9
	WASHINGTON ADVENTIST HOSPITAL	260,306,100	31,746,079	12.20	260,621,900	26,591,693	10.20	-16.2
M E T R O		*13,168,702,649*	*642,642,584*	*4.88*	*13,499,546,969*	*626,713,512*	*4.64*	*-2.5*

CHANGE IN UNCOMPENSATED CARE (UCC): EXHIBIT I-A
REGULATED OPERATIONS
Listed in Alphabetical Order by Region

		2015			2016			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
R U R A L	ATLANTIC GENERAL HOSPITAL	102,371,000	4,685,400	4.58	105,461,500	5,877,300	5.57	25.4
	CALVERT MEMORIAL HOSPITAL	144,499,900	4,821,800	3.34	146,698,600	4,272,000	2.91	-11.4
	CARROLL HOSPITAL CENTER	254,037,700	5,473,796	2.15	254,064,500	7,317,300	2.88	33.7
	FREDERICK MEMORIAL HOSPITAL	346,609,902	11,735,349	3.39	363,795,700	14,836,477	4.08	26.4
	GARRETT COUNTY MEMORIAL HOSPITAL	44,693,600	3,688,206	8.25	48,479,700	3,347,088	6.90	-9.2
	MCCREADY MEMORIAL HOSPITAL	15,059,800	1,147,311	7.62	16,309,200	466,080	2.86	-59.4
	MEDSTAR ST. MARY'S HOSPITAL	166,124,100	8,891,272	5.35	178,043,900	9,293,047	5.22	4.5
	MERITUS MEDICAL CENTER	312,302,400	14,332,763	4.59	321,748,760	15,154,666	4.71	5.7
	PENINSULA REGIONAL MEDICAL CENTER	422,383,500	15,711,300	3.72	430,070,800	17,736,800	4.12	12.9
	UM-CHARLES REGIONAL MEDICAL CENTER	148,386,400	10,105,851	6.81	148,692,700	8,669,229	5.83	-14.2
	UM-HARFORD MEMORIAL HOSPITAL	104,703,700	9,365,100	8.94	104,106,100	6,426,000	6.17	-31.4
	UM-SHORE REGIONAL HEALTH AT CHESTERTOW	64,477,400	4,265,966	6.62	60,065,200	2,989,497	4.98	-29.9
	UM-SHORE REGIONAL HEALTH AT DORCHESTER	56,007,200	3,681,129	6.57	51,452,800	2,500,687	4.86	-32.1
	UM-SHORE REGIONAL HEALTH AT EASTON	192,831,500	10,294,433	5.34	199,614,100	6,973,525	3.49	-32.3
	UNION HOSPITAL OF CECIL COUNTY	157,025,000	7,442,417	4.74	160,304,000	7,698,131	4.80	3.4
	WESTERN MARYLAND REGIONAL MEDICAL CENT	322,958,900	15,587,800	4.83	325,608,000	15,900,100	4.88	2.0
R U R A L		*2,854,472,002*	*131,229,893*	*4.60*	*2,914,515,560*	*129,457,927*	*4.44*	*-1.4*
	Total	*16,023,174,651*	*773,872,476*	*4.83*	*16,414,062,529*	*756,171,438*	*4.61*	*-2.3*

CHANGE IN UNCOMPENSATED CARE (UCC): EXHIBIT I-B
REGULATED OPERATIONS
Listed by Percentage of Uncompensated Care by Region

EXHIBIT I-B. CHANGE IN UNCOMPENSATED CARE, REGULATED OPERATIONS

		2015			2016			
Hospital Area	Hospital	Gross Revenues	Charity & Bad Debts	UCC %	Gross Revenues	Charity & Bad Debts	UCC %	% Change UCC Amount
M E T R O	HOLY CROSS HOSPITAL	480,562,300	38,696,900	8.05	505,712,400	45,443,000	8.99	17.4
	SINAI HOSPITAL	717,312,400	30,113,400	4.20	732,671,600	28,586,943	3.90	-5.1
	UM-BALTIMORE WASHINGTON MEDICAL CENTER	402,010,800	23,399,564	5.82	413,064,200	23,239,033	5.63	-0.7
	UM-UPPER CHESAPEAKE MEDICAL CENTER	320,267,600	16,806,953	5.25	330,967,000	11,900,000	3.60	-29.2
	UM-ST. JOSEPH MEDICAL CENTER	390,826,300	15,978,200	4.09	402,082,700	16,456,039	4.09	3.0
	SHADY GROVE ADVENTIST HOSPITAL	383,323,300	29,442,581	7.68	389,913,200	18,664,288	4.79	-36.6
	JOHNS HOPKINS HOSPITAL	2,209,868,500	49,710,100	2.25	2,282,683,400	47,821,500	2.09	-3.8
	ANNE ARUNDEL MEDICAL CENTER	562,952,500	17,108,400	3.04	576,313,300	14,649,098	2.54	-14.4
	UNIVERSITY OF MARYLAND MEDICAL CENTER	1,313,670,900	36,135,103	2.75	1,345,458,400	54,173,072	4.03	49.9
	UM-SHOCK TRAUMA	197,941,300	24,974,663	12.62	202,325,400	12,183,975	6.02	-51.2
	GREATER BALTIMORE MEDICAL CENTER	432,707,700	10,736,746	2.48	439,684,200	11,490,159	2.61	7.0
	SUBURBAN HOSPITAL	295,844,600	11,753,155	3.97	301,899,200	6,213,087	2.06	-47.1
	MEDSTAR HARBOR HOSPITAL CENTER	207,452,600	10,376,136	5.00	194,368,900	11,195,426	5.76	7.9
	NORTHWEST HOSPITAL CENTER	254,115,900	15,937,500	6.27	257,944,700	14,575,617	5.65	-8.5
	MEDSTAR FRANKLIN SQUARE	491,172,800	20,158,582	4.10	505,736,100	22,427,068	4.43	11.3
	ST. AGNES HOSPITAL	418,876,800	20,902,206	4.99	432,204,400	24,889,102	5.76	19.1
	WASHINGTON ADVENTIST HOSPITAL	260,306,100	31,746,079	12.20	260,621,900	26,591,693	10.20	-16.2
	HOWARD COUNTY GENERAL HOSPITAL	286,302,800	11,859,000	4.14	297,946,200	9,809,000	3.29	-17.3
	MERCY MEDICAL CENTER	495,805,900	31,935,790	6.44	513,599,600	27,253,260	5.31	-14.7

CHANGE IN UNCOMPENSATED CARE (UCC): EXHIBIT I-B
REGULATED OPERATIONS
Listed by Percentage of Uncompensated Care by Region

		2015			2016			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
	MEDSTAR MONTGOMERY MEDICAL CENTER	174,302,200	8,301,281	4.76	175,827,977	7,101,577	4.04	-14.5
	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	618,220,800	40,097,000	6.49	643,455,400	32,847,000	5.10	-18.1
	DOCTORS COMMUNITY HOSPITAL	226,462,500	16,475,191	7.28	234,045,500	17,202,246	7.35	4.4
	MEDSTAR UNION MEMORIAL HOSPITAL	419,374,600	14,810,320	3.53	426,343,800	18,071,382	4.24	22.0
	LEVINDALE	59,785,479	2,454,993	4.11	60,312,800	2,615,214	4.34	6.5
	MEDSTAR GOOD SAMARITAN	303,789,300	12,198,847	4.02	289,108,800	14,558,603	5.04	19.3
	UM-REHABILITATION & ORTHOPAEDIC INSTIT	120,364,600	5,640,901	4.69	118,766,800	7,254,441	6.11	28.6
	UMMC MIDTOWN CAMPUS	228,795,700	24,054,357	10.51	226,817,000	18,527,678	8.17	-23.0
	BOWIE EMERGENCY CENTER	20,111,300	3,395,072	16.88	20,228,300	5,464,725	27.02	61.0
	FORT WASHINGTON MEDICAL CENTER	48,565,970	5,271,258	10.85	48,291,192	4,215,392	8.73	-20.0
	GERMANTOWN EMERGENCY CENTER	14,059,900	2,928,631	20.83	13,555,000	2,998,458	22.12	2.4
	UM-QUEEN ANNE'S FREESTANDING EMERGENCY	4,794,500	255,761	5.33	6,243,200	715,309	11.46	179.7
	PRINCE GEORGES HOSPITAL CENTER	279,091,000	25,794,211	9.24	285,682,600	27,058,517	9.47	4.9
	BON SECOURS HOSPITAL	117,217,800	4,640,014	3.96	106,732,300	3,965,309	3.72	-14.5
	LAUREL REGIONAL HOSPITAL	106,467,900	9,376,744	8.81	106,117,500	12,313,260	11.60	31.3
	MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	262,672,600	15,033,744	5.72	271,938,700	16,181,442	5.95	7.6
	HOLY CROSS HOSPITAL-GERMANTOWN	43,305,400	4,143,200	9.57	80,883,300	8,061,600	9.97	94.6
M E T R O		*13,168,702,649*	*642,642,584*	*4.88*	*13,499,546,969*	*626,713,512*	*4.64*	*-2.5*

CHANGE IN UNCOMPENSATED CARE (UCC): EXHIBIT I-B
REGULATED OPERATIONS
Listed by Percentage of Uncompensated Care by Region

		2015			2016			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
R U R A L	UM-SHORE REGIONAL HEALTH AT EASTON	192,831,500	10,294,433	5.34	199,614,100	6,973,525	3.49	-32.3
	FREDERICK MEMORIAL HOSPITAL	346,609,902	11,735,349	3.39	363,795,700	14,836,477	4.08	26.4
	CARROLL HOSPITAL CENTER	254,037,700	5,473,796	2.15	254,064,500	7,317,300	2.88	33.7
	UM-CHARLES REGIONAL MEDICAL CENTER	148,386,400	10,105,851	6.81	148,692,700	8,669,229	5.83	-14.2
	MERITUS MEDICAL CENTER	312,302,400	14,332,763	4.59	321,748,760	15,154,666	4.71	5.7
	MEDSTAR ST. MARY'S HOSPITAL	166,124,100	8,891,272	5.35	178,043,900	9,293,047	5.22	4.5
	CALVERT MEMORIAL HOSPITAL	144,499,900	4,821,800	3.34	146,698,600	4,272,000	2.91	-11.4
	UM-HARFORD MEMORIAL HOSPITAL	104,703,700	9,365,100	8.94	104,106,100	6,426,000	6.17	-31.4
	WESTERN MARYLAND REGIONAL MEDICAL CENT	322,958,900	15,587,800	4.83	325,608,000	15,900,100	4.88	2.0
	UM-SHORE REGIONAL HEALTH AT CHESTERTOW	64,477,400	4,265,966	6.62	60,065,200	2,989,497	4.98	-29.9
	UM-SHORE REGIONAL HEALTH AT DORCHESTER	56,007,200	3,681,129	6.57	51,452,800	2,500,687	4.86	-32.1
	UNION HOSPITAL OF CECIL COUNTY	157,025,000	7,442,417	4.74	160,304,000	7,698,131	4.80	3.4
	ATLANTIC GENERAL HOSPITAL	102,371,000	4,685,400	4.58	105,461,500	5,877,300	5.57	25.4
	GARRETT COUNTY MEMORIAL HOSPITAL	44,693,600	3,688,206	8.25	48,479,700	3,347,088	6.90	-9.2
	MCCREADY MEMORIAL HOSPITAL	15,059,800	1,147,311	7.62	16,309,200	466,080	2.86	-59.4
	PENINSULA REGIONAL MEDICAL CENTER	422,383,500	15,711,300	3.72	430,070,800	17,736,800	4.12	12.9
R U R A L		*2,854,472,002*	*131,229,893*	*4.60*	*2,914,515,560*	*129,457,927*	*4.44*	*-1.4*
	Total	*16,023,174,651*	*773,872,476*	*4.83*	*16,414,062,529*	*756,171,438*	*4.61*	*-2.3*

CHANGE IN TOTAL OPERATING PROFIT/LOSS: EXHIBIT II-A
REGULATED & UNREGULATED OPERATIONS
Listed by Alphabetical Order

EXHIBIT II-A. CHANGE IN TOTAL OPERATING PROFIT/LOSS, REGULATED AND UNREGULATED OPERATIONS

	2015			2016				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
ANNE ARUNDEL MEDICAL CENTER	47,093,161	-22,286,951	24,806,209	52,222,307	-26,733,963	25,488,344	10.89	2.75
ATLANTIC GENERAL HOSPITAL	14,536,600	-13,654,600	882,000	14,960,419	-12,800,074	2,160,346	2.92	144.91
BON SECOURS HOSPITAL	19,910,902	-10,865,671	9,045,231	13,549,646	-16,979,170	-3,429,524	-31.95	-137.92
BOWIE EMERGENCY CENTER	2,455,821	-821,420	1,634,401	1,546,882	-205,952	1,340,930	-37.01	-17.96
CALVERT MEMORIAL HOSPITAL	19,265,015	-9,491,803	9,773,212	18,720,121	-10,959,061	7,761,059	-2.83	-20.59
CARROLL HOSPITAL CENTER	20,563,115	-4,642,649	15,920,466	20,996,996	-4,664,662	16,332,334	2.11	2.59
DOCTORS COMMUNITY HOSPITAL	18,130,257	-12,010,875	6,119,382	16,518,507	-11,199,116	5,319,391	-8.89	-13.07
FORT WASHINGTON MEDICAL CENTER	2,028,867	-648,722	1,380,145	564,782	-550,815	13,967	-72.16	-98.99
FREDERICK MEMORIAL HOSPITAL	24,767,220	-13,662,174	11,105,045	34,613,957	-15,907,940	18,706,017	39.76	68.45
GARRETT COUNTY MEMORIAL HOSPITAL	3,864,889	208,452	4,073,341	2,734,279	-2,802,488	-68,209	-29.25	-101.67
GERMANTOWN EMERGENCY CENTER	-1,882,264	-37,105	-1,919,369	-1,136,696	-61,445	-1,198,141	39.61	37.58
GREATER BALTIMORE MEDICAL CENTER	40,807,589	-21,120,069	19,687,520	45,141,607	-26,532,465	18,609,142	10.62	-5.48
HOLY CROSS HOSPITAL	50,987,078	-19,378,211	31,608,866	58,855,012	-23,933,345	34,921,667	15.43	10.48
HOLY CROSS HOSPITAL-GERMANTOWN	-20,001,343	-5,186,437	-25,187,780	-10,716,383	-9,099,352	-19,815,736	46.42	21.33
HOWARD COUNTY GENERAL HOSPITAL	17,047,896	-6,610,105	10,437,791	17,176,172	-7,654,570	9,521,602	0.75	-8.78
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	16,998,565	-4,998,765	11,999,800	12,162,463	-5,181,463	6,981,000	-28.45	-41.82
JOHNS HOPKINS HOSPITAL	12,411,383	-2,720,684	9,690,699	26,921,908	-1,419,449	25,502,459	116.91	163.16
LAUREL REGIONAL HOSPITAL	-4,423,106	-12,082,723	-16,505,829	6,569,757	-10,635,648	-4,065,891	248.53	75.37
LEVINDALE	8,251,059	-6,450,535	1,800,524	8,990,071	-4,606,704	4,383,367	8.96	143.45

CHANGE IN TOTAL OPERATING PROFIT/LOSS: EXHIBIT II-A
REGULATED & UNREGULATED OPERATIONS
Listed by Alphabetical Order

	2015			2016				
Hospital	Regulated Operating	Unregulated Operating	Total Operating	Regulated Operating	Unregulated Operating	Total Operating	% Change Reg. Operating	% Change Total Operating
MCCREADY MEMORIAL HOSPITAL	-556,651	46,844	-509,807	-1,419,392	646,215	-773,177	-154.99	-51.66
MEDSTAR FRANKLIN SQUARE	39,840,710	-22,697,960	17,142,750	45,326,578	-34,717,818	10,608,760	13.77	-38.12
MEDSTAR GOOD SAMARITAN	35,670,341	-27,314,012	8,356,329	35,723,964	-31,557,061	4,166,904	0.15	-50.13
MEDSTAR HARBOR HOSPITAL CENTER	23,482,119	-12,398,735	11,083,384	26,909,765	-12,038,506	14,871,259	14.60	34.18
MEDSTAR MONTGOMERY MEDICAL CENTER	14,377,892	-7,766,568	6,611,324	18,166,147	-10,016,939	8,149,209	26.35	23.26
MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	4,107,378	-11,656,520	-7,549,143	13,959,099	-20,416,703	-6,457,604	239.85	14.46
MEDSTAR ST. MARY'S HOSPITAL	22,494,526	-9,227,927	13,266,600	15,810,526	-7,823,621	7,986,905	-29.71	-39.80
MEDSTAR UNION MEMORIAL HOSPITAL	42,313,734	-34,127,034	8,186,700	44,444,733	-39,612,122	4,832,611	5.04	-40.97
MERCY MEDICAL CENTER	19,910,918	-9,289,507	10,621,411	19,356,956	-9,849,369	9,507,587	-2.78	-10.49
MERITUS MEDICAL CENTER	12,342,463	3,917,419	16,259,882	12,719,580	538,790	13,258,370	3.06	-18.46
NORTHWEST HOSPITAL CENTER	33,516,631	-17,063,133	16,453,498	35,182,401	-21,271,014	13,911,387	4.97	-15.45
PENINSULA REGIONAL MEDICAL CENTER	48,494,630	-33,050,630	15,444,000	38,429,325	-39,247,125	-817,800	-20.76	-105.30
PRINCE GEORGES HOSPITAL CENTER	23,737,583	-24,815,306	-1,077,724	30,757,805	-33,825,058	-3,067,254	29.57	-184.60
SHADY GROVE ADVENTIST HOSPITAL	31,683,154	-14,534,203	17,148,951	39,572,732	-13,324,674	26,248,058	24.90	53.06
SINAI HOSPITAL	74,136,800	-36,663,000	37,473,800	74,544,243	-43,649,082	30,895,161	0.55	-17.56
ST. AGNES HOSPITAL	53,691,443	-36,300,907	17,390,536	52,409,602	-42,027,820	10,381,782	-2.39	-40.30
SUBURBAN HOSPITAL	36,471,122	-24,246,141	12,224,980	26,700,494	-9,771,932	16,928,562	-26.79	38.48
UM-BALTIMORE WASHINGTON MEDICAL CENTER	38,372,589	-8,178,153	30,194,436	34,976,908	-4,568,941	30,407,967	-8.85	0.71
UM-CHARLES REGIONAL MEDICAL CENTER	17,413,251	-2,124,433	15,288,818	18,012,966	-3,265,943	14,747,023	3.44	-3.54
UM-HARFORD MEMORIAL HOSPITAL	10,380,504	-1,475,904	8,904,600	9,405,767	-1,894,809	7,510,958	-9.39	-15.65
UM-QUEEN ANNE'S FREESTANDING EMERGENCY	-2,947,220	-15,100	-2,962,320	-1,914,423	0	-1,914,423	35.04	35.37
UM-REHABILITATION & ORTHOPAEDIC INSTIT	626,337	-735,345	-109,008	3,773,387	-490,867	3,282,521	502.45	3111.26

CHANGE IN TOTAL OPERATING PROFIT/LOSS: EXHIBIT II-A
REGULATED & UNREGULATED OPERATIONS
Listed by Alphabetical Order

	2015			2016				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
UM-SHOCK TRAUMA	17,898,888	-104,971	17,793,917	18,116,037	1,157,963	19,274,000	1.21	8.32
UM-SHORE REGIONAL HEALTH AT CHESTERTOW	3,879,516	-2,538,352	1,341,164	6,928,604	-1,978,704	4,949,900	78.59	269.07
UM-SHORE REGIONAL HEALTH AT DORCHESTER	8,291,243	-1,793,599	6,497,644	5,973,138	-1,071,086	4,902,052	-27.96	-24.56
UM-SHORE REGIONAL HEALTH AT EASTON	23,367,326	-3,568,182	19,799,144	25,878,671	-2,815,864	23,062,807	10.75	16.48
UM-ST. JOSEPH MEDICAL CENTER	29,444,823	-18,922,744	10,522,079	45,082,599	-18,755,699	26,326,900	53.11	150.21
UM-UPPER CHESAPEAKE MEDICAL CENTER	43,118,575	-9,088,009	34,030,566	40,076,933	-10,730,960	29,345,972	-7.05	-13.77
UMMC MIDTOWN CAMPUS	23,478,530	-22,025,917	1,452,613	23,977,188	-22,254,688	1,722,500	2.12	18.58
UNION HOSPITAL OF CECIL COUNTY	14,652,783	-12,023,500	2,629,283	16,286,669	-13,168,900	3,117,769	11.15	18.58
UNIVERSITY OF MARYLAND MEDICAL CENTER	48,799,170	-13,076,167	35,723,003	31,915,307	-11,550,307	20,365,000	-34.60	-42.99
WASHINGTON ADVENTIST HOSPITAL	16,639,663	-12,512,993	4,126,670	21,907,859	-12,258,685	9,649,174	31.66	133.82
WESTERN MARYLAND REGIONAL MEDICAL CENT	40,968,696	-19,331,496	21,637,200	36,063,679	-30,079,879	5,983,800	-11.97	-72.34

CHANGE IN TOTAL OPERATING PROFIT/LOSS: EXHIBIT II-B
REGULATED & UNREGULATED OPERATIONS
Listed by Total Operating Profit/Loss

EXHIBIT II-B. CHANGE IN TOTAL OPERATING PROFIT/LOSS, REGULATED AND UNREGULATED OPERATIONS

	2015			2016				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
HOLY CROSS HOSPITAL	50,987,078	-19,378,211	31,608,866	58,855,012	-23,933,345	34,921,667	15.43	10.48
SINAI HOSPITAL	74,136,800	-36,663,000	37,473,800	74,544,243	-43,649,082	30,895,161	0.55	-17.56
UM-BALTIMORE WASHINGTON MEDICAL CENTER	38,372,589	-8,178,153	30,194,436	34,976,908	-4,568,941	30,407,967	-8.85	0.71
UM-UPPER CHESAPEAKE MEDICAL CENTER	43,118,575	-9,088,009	34,030,566	40,076,933	-10,730,960	29,345,972	-7.05	-13.77
UM-ST. JOSEPH MEDICAL CENTER	29,444,823	-18,922,744	10,522,079	45,082,599	-18,755,699	26,326,900	53.11	150.21
SHADY GROVE ADVENTIST HOSPITAL	31,683,154	-14,534,203	17,148,951	39,572,732	-13,324,674	26,248,058	24.90	53.06
JOHNS HOPKINS HOSPITAL	12,411,383	-2,720,684	9,690,699	26,921,908	-1,419,449	25,502,459	116.91	163.16
ANNE ARUNDEL MEDICAL CENTER	47,093,161	-22,286,951	24,806,209	52,222,307	-26,733,963	25,488,344	10.89	2.75
UM-SHORE REGIONAL HEALTH AT EASTON	23,367,326	-3,568,182	19,799,144	25,878,671	-2,815,864	23,062,807	10.75	16.48
UNIVERSITY OF MARYLAND MEDICAL CENTER	48,799,170	-13,076,167	35,723,003	31,915,307	-11,550,307	20,365,000	-34.60	-42.99
UM-SHOCK TRAUMA	17,898,888	-104,971	17,793,917	18,116,037	1,157,963	19,274,000	1.21	8.32
FREDERICK MEMORIAL HOSPITAL	24,767,220	-13,662,174	11,105,045	34,613,957	-15,907,940	18,706,017	39.76	68.45
GREATER BALTIMORE MEDICAL CENTER	40,807,589	-21,120,069	19,687,520	45,141,607	-26,532,465	18,609,142	10.62	-5.48
SUBURBAN HOSPITAL	36,471,122	-24,246,141	12,224,980	26,700,494	-9,771,932	16,928,562	-26.79	38.48
CARROLL HOSPITAL CENTER	20,563,115	-4,642,649	15,920,466	20,996,996	-4,664,662	16,332,334	2.11	2.59
MEDSTAR HARBOR HOSPITAL CENTER	23,482,119	-12,398,735	11,083,384	26,909,765	-12,038,506	14,871,259	14.60	34.18
UM-CHARLES REGIONAL MEDICAL CENTER	17,413,251	-2,124,433	15,288,818	18,012,966	-3,265,943	14,747,023	3.44	-3.54
NORTHWEST HOSPITAL CENTER	33,516,631	-17,063,133	16,453,498	35,182,401	-21,271,014	13,911,387	4.97	-15.45
MERITUS MEDICAL CENTER	12,342,463	3,917,419	16,259,882	12,719,580	538,790	13,258,370	3.06	-18.46

CHANGE IN TOTAL OPERATING PROFIT/LOSS: EXHIBIT II-B
REGULATED & UNREGULATED OPERATIONS
Listed by Total Operating Profit/Loss

	2015			2016				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
MEDSTAR FRANKLIN SQUARE	39,840,710	-22,697,960	17,142,750	45,326,578	-34,717,818	10,608,760	13.77	-38.12
ST. AGNES HOSPITAL	53,691,443	-36,300,907	17,390,536	52,409,602	-42,027,820	10,381,782	-2.39	-40.30
WASHINGTON ADVENTIST HOSPITAL	16,639,663	-12,512,993	4,126,670	21,907,859	-12,258,685	9,649,174	31.66	133.82
HOWARD COUNTY GENERAL HOSPITAL	17,047,896	-6,610,105	10,437,791	17,176,172	-7,654,570	9,521,602	0.75	-8.78
MERCY MEDICAL CENTER	19,910,918	-9,289,507	10,621,411	19,356,956	-9,849,369	9,507,587	-2.78	-10.49
MEDSTAR MONTGOMERY MEDICAL CENTER	14,377,892	-7,766,568	6,611,324	18,166,147	-10,016,939	8,149,209	26.35	23.26
MEDSTAR ST. MARY'S HOSPITAL	22,494,526	-9,227,927	13,266,600	15,810,526	-7,823,621	7,986,905	-29.71	-39.80
CALVERT MEMORIAL HOSPITAL	19,265,015	-9,491,803	9,773,212	18,720,121	-10,959,061	7,761,059	-2.83	-20.59
UM-HARFORD MEMORIAL HOSPITAL	10,380,504	-1,475,904	8,904,600	9,405,767	-1,894,809	7,510,958	-9.39	-15.65
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	16,998,565	-4,998,765	11,999,800	12,162,463	-5,181,463	6,981,000	-28.45	-41.82
WESTERN MARYLAND REGIONAL MEDICAL CENT	40,968,696	-19,331,496	21,637,200	36,063,679	-30,079,879	5,983,800	-11.97	-72.34
DOCTORS COMMUNITY HOSPITAL	18,130,257	-12,010,875	6,119,382	16,518,507	-11,199,116	5,319,391	-8.89	-13.07
UM-SHORE REGIONAL HEALTH AT CHESTERTOW	3,879,516	-2,538,352	1,341,164	6,928,604	-1,978,704	4,949,900	78.59	269.07
UM-SHORE REGIONAL HEALTH AT DORCHESTER	8,291,243	-1,793,599	6,497,644	5,973,138	-1,071,086	4,902,052	-27.96	-24.56
MEDSTAR UNION MEMORIAL HOSPITAL	42,313,734	-34,127,034	8,186,700	44,444,733	-39,612,122	4,832,611	5.04	-40.97
LEVINDALE	8,251,059	-6,450,535	1,800,524	8,990,071	-4,606,704	4,383,367	8.96	143.45
MEDSTAR GOOD SAMARITAN	35,670,341	-27,314,012	8,356,329	35,723,964	-31,557,061	4,166,904	0.15	-50.13
UM-REHABILITATION & ORTHOPAEDIC INSTIT	626,337	-735,345	-109,008	3,773,387	-490,867	3,282,521	502.45	3111.26
UNION HOSPITAL OF CECIL COUNTY	14,652,783	-12,023,500	2,629,283	16,286,669	-13,168,900	3,117,769	11.15	18.58
ATLANTIC GENERAL HOSPITAL	14,536,600	-13,654,600	882,000	14,960,419	-12,800,074	2,160,346	2.92	144.91
UMMC MIDTOWN CAMPUS	23,478,530	-22,025,917	1,452,613	23,977,188	-22,254,688	1,722,500	2.12	18.58
BOWIE EMERGENCY CENTER	2,455,821	-821,420	1,634,401	1,546,882	-205,952	1,340,930	-37.01	-17.96

CHANGE IN TOTAL OPERATING PROFIT/LOSS: EXHIBIT II-B
REGULATED & UNREGULATED OPERATIONS
Listed by Total Operating Profit/Loss

	2015			2016				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
FORT WASHINGTON MEDICAL CENTER	2,028,867	-648,722	1,380,145	564,782	-550,815	13,967	-72.16	-98.99
GARRETT COUNTY MEMORIAL HOSPITAL	3,864,889	208,452	4,073,341	2,734,279	-2,802,488	-68,209	-29.25	-101.67
MCCREADY MEMORIAL HOSPITAL	-556,651	46,844	-509,807	-1,419,392	646,215	-773,177	-154.99	-51.66
PENINSULA REGIONAL MEDICAL CENTER	48,494,630	-33,050,630	15,444,000	38,429,325	-39,247,125	-817,800	-20.76	-105.30
GERMANTOWN EMERGENCY CENTER	-1,882,264	-37,105	-1,919,369	-1,136,696	-61,445	-1,198,141	39.61	37.58
UM-QUEEN ANNE'S FREESTANDING EMERGENCY	-2,947,220	-15,100	-2,962,320	-1,914,423	0	-1,914,423	35.04	35.37
PRINCE GEORGES HOSPITAL CENTER	23,737,583	-24,815,306	-1,077,724	30,757,805	-33,825,058	-3,067,254	29.57	-184.60
BON SECOURS HOSPITAL	19,910,902	-10,865,671	9,045,231	13,549,646	-16,979,170	-3,429,524	-31.95	-137.92
LAUREL REGIONAL HOSPITAL	-4,423,106	-12,082,723	-16,505,829	6,569,757	-10,635,648	-4,065,891	248.53	75.37
MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	4,107,378	-11,656,520	-7,549,143	13,959,099	-20,416,703	-6,457,604	239.85	14.46
HOLY CROSS HOSPITAL-GERMANTOWN	-20,001,343	-5,186,437	-25,187,780	-10,716,383	-9,099,352	-19,815,736	46.42	21.33

EXHIBIT III A. EXCESS PROFIT/LOSS

	2015	2016	
Hospital	**Excess/Profit Loss**	**Excess/Profit Loss**	**% Change in Excess**
ALL ACUTE HOSPITALS	529,689,423	361,792,660	-31.70
ANNE ARUNDEL MEDICAL CENTER	-16,185,791	-12,410,456	23.32
ATLANTIC GENERAL HOSPITAL	2,442,300	2,423,915	-0.75
BON SECOURS HOSPITAL	9,344,231	-3,177,386	-134.00
BOWIE EMERGENCY CENTER	1,634,401	1,340,930	-17.96
CALVERT MEMORIAL HOSPITAL	7,641,171	8,763,974	14.69
CARROLL HOSPITAL CENTER	11,992,597	16,640,634	38.76
DOCTORS COMMUNITY HOSPITAL	5,096,695	1,397,774	-72.57
FORT WASHINGTON MEDICAL CENTER	1,380,752	14,629	-98.94
FREDERICK MEMORIAL HOSPITAL	11,684,445	12,241,017	4.76
GARRETT COUNTY MEMORIAL HOSPITAL	4,805,317	266,348	-94.46
GERMANTOWN EMERGENCY CENTER	-2,327,154	-1,616,159	30.55
GREATER BALTIMORE MEDICAL CENTER	22,310,520	13,662,336	-38.76
HOLY CROSS HOSPITAL	37,702,162	28,838,267	-23.51
HOLY CROSS HOSPITAL-GERMANTOWN	-25,330,007	-20,514,095	19.01
HOWARD COUNTY GENERAL HOSPITAL	9,198,800	4,610,200	-49.88
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	13,875,000	9,114,900	-34.31
JOHNS HOPKINS HOSPITAL	49,280,467	62,300,768	26.42
LAUREL REGIONAL HOSPITAL	-9,114,741	-1,232,453	86.48
LEVINDALE	780,648	3,926,188	402.94
MCCREADY MEMORIAL HOSPITAL	-425,502	-699,147	-64.31
MEDSTAR FRANKLIN SQUARE	17,341,909	10,758,078	-37.96
MEDSTAR GOOD SAMARITAN	10,737,176	6,154,704	-42.68
MEDSTAR HARBOR HOSPITAL CENTER	11,457,920	14,195,125	23.89
MEDSTAR MONTGOMERY MEDICAL CENTER	6,619,082	8,150,360	23.13
MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	-7,528,697	-6,456,935	14.24
MEDSTAR ST. MARY'S HOSPITAL	13,257,796	7,987,366	-39.75
MEDSTAR UNION MEMORIAL HOSPITAL	9,579,971	4,215,211	-56.00
MERCY MEDICAL CENTER	16,544,255	7,945,460	-51.97
MERITUS MEDICAL CENTER	18,328,621	-20,927,920	-214.18

TOTAL EXCESS PROFIT/LOSS: EXHIBIT III-A
Listed by Alphabetical Order

	2015	2016	
Hospital	Excess/Profit Loss	Excess/Profit Loss	% Change in Excess
NORTHWEST HOSPITAL CENTER	18,792,218	9,135,910	-51.38
PENINSULA REGIONAL MEDICAL CENTER	24,068,000	6,837,000	-71.59
PRINCE GEORGES HOSPITAL CENTER	17,696,121	4,642,564	-73.77
SHADY GROVE ADVENTIST HOSPITAL	18,326,992	25,279,622	37.94
SINAI HOSPITAL	45,201,800	26,647,161	-41.05
ST. AGNES HOSPITAL	18,700,440	3,177,083	-83.01
SUBURBAN HOSPITAL	9,813,980	10,231,562	4.25
UM-BALTIMORE WASHINGTON MEDICAL CENTER	26,587,436	24,916,967	-6.28
UM-CHARLES REGIONAL MEDICAL CENTER	14,283,818	13,560,023	-5.07
UM-HARFORD MEMORIAL HOSPITAL	9,405,600	8,000,958	-14.93
UM-QUEEN ANNE'S FREESTANDING EMERGENCY	-2,956,067	-1,958,423	33.75
UM-REHABILITATION & ORTHOPAEDIC INSTIT	-633,008	2,225,521	451.58
UM-SHOCK TRAUMA	19,293,917	20,774,000	7.67
UM-SHORE REGIONAL HEALTH AT CHESTERTOW	1,174,180	4,546,900	287.24
UM-SHORE REGIONAL HEALTH AT DORCHESTER	6,542,898	4,579,237	-30.01
UM-SHORE REGIONAL HEALTH AT EASTON	19,502,785	19,341,807	-0.83
UM-ST. JOSEPH MEDICAL CENTER	7,725,079	22,824,900	195.46
UM-UPPER CHESAPEAKE MEDICAL CENTER	23,343,566	30,135,972	29.10
UMMC MIDTOWN CAMPUS	943,613	1,178,500	24.89
UNION HOSPITAL OF CECIL COUNTY	2,163,183	2,859,969	32.21
UNIVERSITY OF MARYLAND MEDICAL CENTER	-6,223,997	-51,452,000	-726.67
WASHINGTON ADVENTIST HOSPITAL	2,625,923	8,433,093	221.15
WESTERN MARYLAND REGIONAL MEDICAL CENT	21,186,600	7,960,700	-62.43

EXHIBIT III B. EXCESS PROFIT/LOSS

	2015	2016	
Hospital	Excess/Profit Loss	Excess/Profit Loss	% Change in Excess
JOHNS HOPKINS HOSPITAL	49,280,467	62,300,768	26.42
UM-UPPER CHESAPEAKE MEDICAL CENTER	23,343,566	30,135,972	29.10
HOLY CROSS HOSPITAL	37,702,162	28,838,267	-23.51
SINAI HOSPITAL	45,201,800	26,647,161	-41.05
SHADY GROVE ADVENTIST HOSPITAL	18,326,992	25,279,622	37.94
UM-BALTIMORE WASHINGTON MEDICAL CENTER	26,587,436	24,916,967	-6.28
UM-ST. JOSEPH MEDICAL CENTER	7,725,079	22,824,900	195.46
UM-SHOCK TRAUMA	19,293,917	20,774,000	7.67
UM-SHORE REGIONAL HEALTH AT EASTON	19,502,785	19,341,807	-0.83
CARROLL HOSPITAL CENTER	11,992,597	16,640,634	38.76
MEDSTAR HARBOR HOSPITAL CENTER	11,457,920	14,195,125	23.89
GREATER BALTIMORE MEDICAL CENTER	22,310,520	13,662,336	-38.76
UM-CHARLES REGIONAL MEDICAL CENTER	14,283,818	13,560,023	-5.07
FREDERICK MEMORIAL HOSPITAL	11,684,445	12,241,017	4.76
MEDSTAR FRANKLIN SQUARE	17,341,909	10,758,078	-37.96
SUBURBAN HOSPITAL	9,813,980	10,231,562	4.25
NORTHWEST HOSPITAL CENTER	18,792,218	9,135,910	-51.38
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	13,875,000	9,114,900	-34.31
CALVERT MEMORIAL HOSPITAL	7,641,171	8,763,974	14.69
WASHINGTON ADVENTIST HOSPITAL	2,625,923	8,433,093	221.15
MEDSTAR MONTGOMERY MEDICAL CENTER	6,619,082	8,150,360	23.13
UM-HARFORD MEMORIAL HOSPITAL	9,405,600	8,000,958	-14.93
MEDSTAR ST. MARY'S HOSPITAL	13,257,796	7,987,366	-39.75
WESTERN MARYLAND REGIONAL MEDICAL CENT	21,186,600	7,960,700	-62.43
MERCY MEDICAL CENTER	16,544,255	7,945,460	-51.97
PENINSULA REGIONAL MEDICAL CENTER	24,068,000	6,837,000	-71.59
MEDSTAR GOOD SAMARITAN	10,737,176	6,154,704	-42.68
PRINCE GEORGES HOSPITAL CENTER	17,696,121	4,642,564	-73.77
HOWARD COUNTY GENERAL HOSPITAL	9,198,800	4,610,200	-49.88
UM-SHORE REGIONAL HEALTH AT DORCHESTER	6,542,898	4,579,237	-30.01

TOTAL EXCESS PROFIT/LOSS: EXHIBIT III-B
Listed by Excess Profit/Loss

	2015	2016	
Hospital	Excess/Profit Loss	Excess/Profit Loss	% Change in Excess
UM-SHORE REGIONAL HEALTH AT CHESTERTOW	1,174,180	4,546,900	287.24
MEDSTAR UNION MEMORIAL HOSPITAL	9,579,971	4,215,211	-56.00
LEVINDALE	780,648	3,926,188	402.94
ST. AGNES HOSPITAL	18,700,440	3,177,083	-83.01
UNION HOSPITAL OF CECIL COUNTY	2,163,183	2,859,969	32.21
ATLANTIC GENERAL HOSPITAL	2,442,300	2,423,915	-0.75
UM-REHABILITATION & ORTHOPAEDIC INSTIT	-633,008	2,225,521	451.58
DOCTORS COMMUNITY HOSPITAL	5,096,695	1,397,774	-72.57
BOWIE EMERGENCY CENTER	1,634,401	1,340,930	-17.96
UMMC MIDTOWN CAMPUS	943,613	1,178,500	24.89
GARRETT COUNTY MEMORIAL HOSPITAL	4,805,317	266,348	-94.46
FORT WASHINGTON MEDICAL CENTER	1,380,752	14,629	-98.94
MCCREADY MEMORIAL HOSPITAL	-425,502	-699,147	-64.31
LAUREL REGIONAL HOSPITAL	-9,114,741	-1,232,453	86.48
GERMANTOWN EMERGENCY CENTER	-2,327,154	-1,616,159	30.55
UM-QUEEN ANNE'S FREESTANDING EMERGENCY	-2,956,067	-1,958,423	33.75
BON SECOURS HOSPITAL	9,344,231	-3,177,386	-134.00
MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	-7,528,697	-6,456,935	14.24
ANNE ARUNDEL MEDICAL CENTER	-16,185,791	-12,410,456	23.32
HOLY CROSS HOSPITAL-GERMANTOWN	-25,330,007	-20,514,095	19.01
MERITUS MEDICAL CENTER	18,328,621	-20,927,920	-214.18
UNIVERSITY OF MARYLAND MEDICAL CENTER	-6,223,997	-51,452,000	-726.67

Legislative Update

The Legislative Update will be presented at the Commission Meeting

Update from CRISP

Representatives from CRISP will present slides and materials during the Commission meeting

State of Maryland
Department of Health and Mental Hygiene

Nelson J. Sabatini
Chairman

Herbert S. Wong, PhD
Vice-Chairman

Joseph Antos, PhD

Victoria W. Bayless

George H. Bone, M.D.

John M. Colmers

Jack C. Keane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Katie Wunderlich, Director
Engagement
and Alignment

Vacant, Director
Population Based
Methodologies

Chris L. Peterson, Director
Clinical and Financial
Information

Gerard J. Schmith, Director
Revenue and Regulation
Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **April 12, 2017**

RE: **Hearing and Meeting Schedule**

May 10, 2017	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
June 14, 2017	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/commission-meetings-2017.cfm.

Post-meeting documents will be available on the Commission's website following the Commission meeting.