State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

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Vice-Chairman

George H. Bone,
M.D.

Stephen F. Jencks,
M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus,
M.D.

Thomas R. Mullen

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

Stephen Ports
Principal Deputy Director
Policy and Operations

David Romans
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

524th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 18, 2015

EXECUTIVE SESSION
12:00 p.m.
(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

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, §3-104**
2. **Consultation with Legal Counsel on Legal Authority for Rate Application Moratorium – General Provisions Article - §3-305(b)(7)**
3. **Personnel Matters - General Provisions Article, §3-305 (b)(1)(ii)**

PUBLIC SESSION OF THE HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on October 14, 2015**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2300R – Washington Adventist Hospital
   2309A - University of Maryland Medical Center
   2312A - University of Maryland Medical Center
   2313A - University of Maryland Medical Center

5. **Docket Status – Cases Open**

   2304N – UM St. Joseph Medical Center
   2307A – Maryland Physician Care
   2308A – Priority Partners
   2310A – MedStar Family Choice
   2311A – MedStar Family Choice
   2314A – Riverside Health of Maryland
   2315A – Johns Hopkins Health System
   2316A – Johns Hopkins Health System
   2317R – Holy Cross Health
   2318A – University of Maryland Medical System

6. **Preliminary Staff Report Regarding Health Job Opportunity Program Proposal**

7. **Update from Performance Measurement Work Group**

8. **Disclosure of the Hospital Financial and Statistical Data for Fiscal Year 2014**

9. **Legal Report**

10. **Hearing and Meeting Schedule**

Closed Session Minutes
of the
Health Services Cost Review Commission

October 14, 2015

Upon motion made in public session, Chairman Colmers call for adjournment into closed session to discuss the following items:

1. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract;

The Closed Session was called to order at 12:02 p.m. and held under authority of - § 3-104 of the General Provisions Article.

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, Mullen and Wong. Commissioner Loftus participated by telephone.

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, Sule Gerovich, Ellen Englert, Jessica Lee, and Dennis Phelps.

Also attending were Deborah Gracey of Health Management Associates and Stan Lustman, Commission Counsel.

Item One

Steve Ports, Principal Deputy Director, updated the Commission on a shared stakeholder process with the Department of Health and Mental Hygiene in order to develop a vision for Phase 1.5 and 2.0 of the Model.

Item Two

Donna Kinzer, Executive Director, and David Romans, Director-Payment Reform and Innovation, presented and the Commission discussed an updated analysis of Medicare per beneficiary data.

The Closed Session was adjourned at 1:02 p.m.

MINUTES OF THE
523rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

October 14, 2015

Chairman John Colmers called the public meeting to order at 12:02 pm. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Thomas Mullen, and Herbert S. Wong, Ph.D. were also in attendance. Bernadette C. Loftus, M.D., joined the meeting via telephone. Upon motion made by Commissioner Jencks and seconded by Commissioner Wong, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:10 pm.

REPORT OF THE OCTOBER 14, 2015 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the October 14, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM SEPTEMBER 9, 2015 EXECUTIVE SESSION AND PUBLIC MEETING AND OCTOBER 1, 2015 EXECUTIVE SESSION

The Commission voted unanimously to approve the minutes of the September 9, 2015 Executive Session and Public Meeting and the October 1, 2015 Executive Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, provided an update on the Health Job Opportunity Program Proposal (the Proposal) introduced at last month's public meeting. The Proposal suggests that the HSCRC provide up to $40 million through hospital rates to establish about 1,000 entry level health jobs in areas of extreme poverty and unemployment. This proposal came about due to the unrest in Baltimore City and the belief that employment is an important element needed to change the current situation. The Proposal seeks to create community based jobs that can contribute to improved community health, as well as hospital jobs that create employment opportunities in economically challenged areas.

Ms. Kinzer noted that the Payment Model Workgroup held a meeting on October 5th to discuss the Proposal and other topics. Program description materials and a series of questions were sent out prior to the meeting and are posted at the HSCRC website. Comments were also accepted from individuals attending the meeting.

The work group members and commenters expressed their appreciation for the leadership in bringing forward this job proposal.

Comment letters received noted the following concerns:

- It was important to define success. Success would need to be framed not only in creating jobs but also in the context of the New All Payer Model and Triple Aim of improving care, improving health, lowering costs.

- It would be important to focus on jobs outside of the hospitals such as Community Health Workers. The concern was raised that the reduction of avoidable utilization in hospitals might reduce the need for some of the hospital jobs that were part of the Proposal.

- That the infrastructure adjustments already provided to hospitals or the additional amount that is slated for award in January 2016, which focuses on similar activities, would be a duplicate effort.

- It was suggested that other funding sources be considered for Proposal implementation

- If the Proposal were to move forward, much more detailed design work needs to take place.

Mr. Melvin Wilson, Executive Director of Turnaround Tuesday a jobs movement of Baltimore United in Leadership Development (BUILD), expressed support for the job proposal.

Staff is currently considering all oral and written comments and will report back to the Commission at the November Commission meeting.

Ms. Kinzer stated that Staff has been paying attention to Medicare growth in charges and utilization. Ms. Kinzer noted that there has been an uptick in Medicare volumes, and that this increase is likely affecting Medicare savings. Staff will continue to monitor the situation closely and consider whether any special actions or policy changes are necessary.

Ms. Kinzer stated that from fiscal year 2013 to 2014, there were increases in orthopedic surgery and oncology service lines for Medicare patients. She noted that these increases were more than offset by decreases in avoidable utilization such as readmissions and Prevention Quality Indicator (PQI) admissions, with a net reduction in Equivalent Case Mix Adjusted Discharges (ECMADs).

Ms. Kinzer stated that from fiscal year 2014 to 2015, there were larger increases in orthopedic surgery and oncology services for Medicare patients with a modest reduction in readmissions; however, there was an increase in PQI admissions as well as other medical admissions for the period. The result was an increase of 2.09% in ECMADs in FY 2015. She noted that the rate adjustments provided by the Commission for July 1, 2014 and July 1, 2015 are based on the assumption that Medicare per capita growth will be lower than the All Payer growth by 2%. The calendar year per capita growth per resident in All Payer revenue through August 2015 versus the same period in 2014 was 2.5%. The Medicare growth for the same period was 1.71%, with a

gap at .79% rather than the projected 2%.

Ms. Kinzer noted that success of the All Payer Model is dependent on reducing avoidable utilization. Hospitals will need to accelerate their efforts to reduce avoidable utilization in order to achieve the volume levels that support the savings requirements for Medicare. Staff notes that a number of planning efforts are underway, and some hospitals have implemented significant interventions. However, there is significant work to be done to reduce avoidable utilization, including working closely with primary care physicians to coordinate care and address chronic conditions more effectively, implementing comprehensive care coordination for high needs and complex patients, and working with post-acute and long term care facilities to reduce avoidable hospitalizations. In addition, Ms. Kinzer noted at the same time Medicare hospital utilization increased, there was also an increase in payments to SNFs. HSCRC staff will investigate these two trends and consider the implications.

Ms. Kinzer stated that CMS has granted Maryland an exemption from the national Medicare Value Based Purchasing Program for FY 2016. CMS notes that Maryland significantly lags national performance in patient experience of care in the Hospital Consumer Assessment of Healthcare Providers and System surveys. As a result of this lagging performance, HSCRC has assigned a higher proportion of the weighting to this domain and has increased the amount of revenue at risk for this program.

Ms. Kinzer noted that Staff is currently focused on the following activities:

- Issuing amended rate orders that adjust for final reconciliation of GBR/TPR and rate compliance and Quality Based Reimbursement (QBR) program performance
- Reviewing radiation therapy, infusion, and chemotherapy market shift adjustments with stakeholders
- Reviewing Certificate of Need applications that have been filed
- Moving forward on updates to value based performance measures, including efficiency measures
- Turning to focus on per capita costs and total cost of care, for purposes of monitoring and also to progress toward a focus on outcomes and cost across the health care system.
- Preparing to finalize and implement a stakeholder process that will be executed together with DHMH and other agencies, focused on developing a vision for Phase 2 of the All Payer Model and developing interim approaches that will provide progression toward Phase 2. Medicaid is evaluating formation of an ACO like model for dual eligible enrollees (beneficiaries with both Medicare and Medicaid coverage). This process will be combined with the stakeholder process for progressing on the All Payer Model.
- Staff is evaluating proposals received for support of the Phase 2 application development and application process with CMMI, together with other state agencies.

Ms. Kinzer introduced Ms. Erin Schurmann as the new Project Manager. Ms. Kinzer also introduced Ms. Andrea Zumbrum as the new Policy Analyst and Mr. William Hoff as the new Assistant Chief of Audit and Compliance.

Steve Ports, Deputy Director Policy and Operations, updated the Commission on staff's plans to use the HSCRC's Advisory Council to shape the vision and guiding principles for the next phases of the All Payer Model and presented staff's recommendation that new members be added to the Advisory Council. These new members would have expertise in acute and long term care as well as physician expertise. The Commission voted unanimously to approve staff's recommendation.

ITEM III
NEW MODEL MONITORING

Mr. David Romans, Director Payment Reform and Innovation, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of August focuses on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the two month period ended August 30, 2015, All-Payer total gross revenue increased by 3.86% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 4.15%; this translates to a per capita growth of 3.57%. All-Payer gross revenue for non-Maryland residents increased by 1.05%.

Mr. Romans reported that for the eight months of the calendar year ended August 30, 2015, All-Payer total gross revenue increased by 2.68% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 3.07%; this translates to a per capita growth of 2.50%. All-Payer gross revenue for non-Maryland residents decreased by 1.25%.

Mr. Romans reported that for the two months ended August 30, 2015, Medicare Fee-For-Service gross revenue increased by 4.77% over the same period in FY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 5.13%; this translates to a per capita growth of 2.03%. Maryland Fee-For-Service gross revenue for non-residents increased by 0.80%.

Mr. Romans reported that for the eight months of the calendar year ended August 30, 2015, Medicare Fee-For-Service gross revenue increased by 4.35%. Medicare Fee-For-Service gross revenue for Maryland residents increased by 5.01%; this translates to a per capita growth of 1.71 %. Maryland Fee-For-Service gross revenue for non-residents decreased by 2.89%.

According to Mr. Romans, for the two months of the fiscal year ended August 30, 2015, unaudited average operating profit for acute hospitals was 4.29%. The median hospital profit was 4.26%, with a distribution of 1.24% in the 25th percentile and 7.48% in the 75th percentile. Rate Regulated profits were 8.40%.

Dr. Sule Gerovich Ph.D., Deputy Director Research and Methodology, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon Potentially Preventable Complications (PPCs) data and discharges through June 2015 and readmission data on discharges through July 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.87 % for the period of January 2015 to July 2015. This is a cumulative decrease of 6.84% from the July 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 13.72% for the period January 2015 to July 2015 YTD. This is an accumulated decrease of 5.81% from the July 2013 risk adjusted readmission rate.
- Based on the New-Payer Model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set the goals for hospitals to reduce their risk adjusted readmission rate by 9.3% during CY2015 compared to CY2013. Currently, only 15 out of 46 hospitals have reduced their risk adjusted rate by more than 9.3%.

Potentially Preventable Complications

- The All-Payer risk adjusted PPC rate was 0.83 for June 2015 YTD. This is a decrease of 35.66% from the June 2013 YTD risk adjusted PPC rate.
- The Medicare Fee for Service risk adjusted PPC rate was 0.96 for June 2015 YTD. This is a decrease of 38.46% from the June 2013 YTD risk adjusted PPC rate.

ITEM IV
DOCKET STATUS CASES CLOSED

2306A – University of Maryland Medical Center

ITEM V
DOCKET STATUS- OPEN CASES

2300R Washington Adventist Hospital

Jerry Schmith, Deputy Director Hospital Rate Setting, summarized Staff 's final recommendation for the Washington Adventist Hospital (WAH) rate application request that rates be increased in FY 2019 to help pay for a large capital cost increase associated with the construction of a replacement facility in a new location in White Oak, Maryland. This partial rate application is being filed during the Certificate of Need (CON) review, which is underway at the Maryland Health Care Commission (MHCC). This rate request is being filed in advance of CON approval because WAH represented in its CON application that it will require a rate increase to make the project feasible. After the rate application is acted upon, the HSCRC staff will provide a feasibility evaluation on the project to MHCC. If WAH finances the project through MHHEFA, it would to seek a Comfort Order from the HSCRC.

The total cost of the proposed project is $330,829,524. WAH proposes to contribute $50,575,175 in cash and $11,000,000 in land towards the project. It will also fundraise an additional $20,000,000 and finance the remainder with the sale of $244,750,000 in bonds and $4,504,349 of

related interest earnings.

WAH requests a permanent revenue increase of $19,700,000 or 7.3 percent of its total approved permanent revenue. WAH is requesting that 50 percent of the revenue increase be effective on January 1, 2019, the anticipated opening date of the new facility in White Oak, Maryland. WAH is requesting that the remaining 50 percent of the revenue increase be effective on July 1, 2019. The requested revenue increase represents approximately 80 percent of the estimated additional depreciation and interest costs associated with the project.

Staff recommends the following:

- That $15,391,282 be added to WAH's permanent rate base at the time the facility opens, estimated to be January 1, 2019. This revenue adjustment will be reduced if the actual interest rate incurred is different from the projected 6 percent used in these calculations.
- That revenue approved is based on the information and representations contained within the Hospital's CON application. Should the information and representations change materially in the view of HSCRC staff, staff reserves the right to bring this matter back to the HSCRC for reevaluation and potential modification to the approved revenue.
- That WAH will continue to be subject to any revenue adjustments related to the Global Budget Revenue or any new rate setting system developed in response to changes in health care delivery or payment methodologies in Maryland. Staff is in the process of developing new rate methodologies over the next few years that will account for operational efficiencies and ongoing efforts to reduce potentially avoidable utilization.
- That staff recommendation should not be construed in any way as staff's rendering any opinion at this time on the financial feasibility of the capital project.

The Commission voted unanimously to approve staff's recommendation.

2307A- Maryland Physician Care

Mr. Ports summarized staff's draft recommendation on the application filed by Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health (the "Hospitals"). The Hospitals are seeking approval for continued participation of Maryland Physician Care in the Medicaid Health Choice Program. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2016.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

2308A- Priority Partners

Mr. Ports summarized staff's draft recommendation on the application filed by Johns Hopkins Health System (the "System") on behalf of John Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, and Suburban Hospital (the "Hospitals"). The System is seeking approval for continued participation of Priority Partners, Inc. in the Medicaid

Health Choice Program. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2016.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

2309A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital") filed an application on September 18, 2015 requesting continued participation in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. beginning November 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning November 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2310A- MedStar Family Choice

Mr. Ports summarized Staff's draft recommendation on the application of the MedStar Health System on behalf of Franklin Square Hospital, Good Samaritan, Harbor Hospital and Union Memorial Hospital. MedStar Health seeks renewal for continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program for one year beginning in January 1, 2015.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

2312A-University of Maryland

The University of Maryland Medical Center (the "Hospital") filed an application on September 28, 2015 requesting continued participation in a global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers beginning November 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning November 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2313A-University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on September 28, 2015 seeking approval to participate in a new global rate arrangement with Humana for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning November 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2314A University of Maryland Medical Systems

Mr. Ports summarized Staff's draft recommendation on the application of Riverside Health ("Riverside"), a Medicaid Managed Care Organization (MCO), on behalf of the University of Maryland Medical System Corporation (the "Hospitals). Riverside and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program for one year beginning January 1, 2016.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

ITEM VI
FINAL RECOMMENDATIONS ON REVISIONS TO THE QUALITY BASED REIMBURSEMENT PROGRAM FOR RATE YEAR 2018

Ms. Dianne Feeney, Associate Director Quality Initiative, presented Staff's Final recommendation on updating the Quality Based Reimbursement (QBR) Program for FY2018 (See "Final Recommendation for Updating the Quality Based Reimbursement Program for FY 2018" on the HSCRC website).

HSCRC quality based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for those programs, are important tools for providing strong incentives for hospitals to improve their quality performance over time. HSCRC implemented the first hospital adjustments for the QBR Program performance in July 2009. Current Commission policy calls for measurement of hospital performance scores across clinical processes of care, outcome and patient experience of care domains, and scaling of hospital performance results in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base regulated hospital inpatient revenue based on assessment of the quality of hospital performance. The rewards (positive scale amounts) or penalties (negative scaled amounts) are then applied to

each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis and are not considered permanent revenue.

For FY 2018, HSCRC staff final recommendations include adjusting the weights and updating the measurement domains to be consistent as possible with the Centers for Medicare and Medicaid Services (CMS) Value Based Purchasing Program. They also include holding steady the amount of total hospital revenue at risk for scaling for the QBR Program

The proposed final recommendations for the QBR Program are as follows:

- Continue to allocate 2 percent of hospital approved inpatient revenue for QBR performance in FY 2018 to be finalized by the Aggregate Revenue "at risk" recommendation.
- Adjust measurement domain weights to include: 50 percent for Patient Experience Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
LEGAL REPORT

Regulations

Final Action

Rate Application and Approval Procedures – COMAR 10.37.10.26-1

The purpose of this action is to impose a moratorium on the Commission's Maryland Health Insurance Plan (MHIP) assessment for Fiscal Year 2016 in response to the Budget Reconciliation Act of 2015 changes to the program as of July 1, 2015. This proposed regulatory change appeared in the July 24, 2015 issue of the Maryland Register (42:15 Md. R. 1026-1027).

The Commission voted unanimously to approve the final adoption of the proposed regulation.

ITEM VIII
HEARING AND MEETING SCHEDULE

November 18, 2015 Times to be determined, 4160 Patterson Avenue
HSCRC Conference Room

December 9, 2015 Times to be determined, 4160 Patterson Avenue
HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:35 pm.

Executive Director's Report

Health Services Cost Review Commission

November 18, 2015

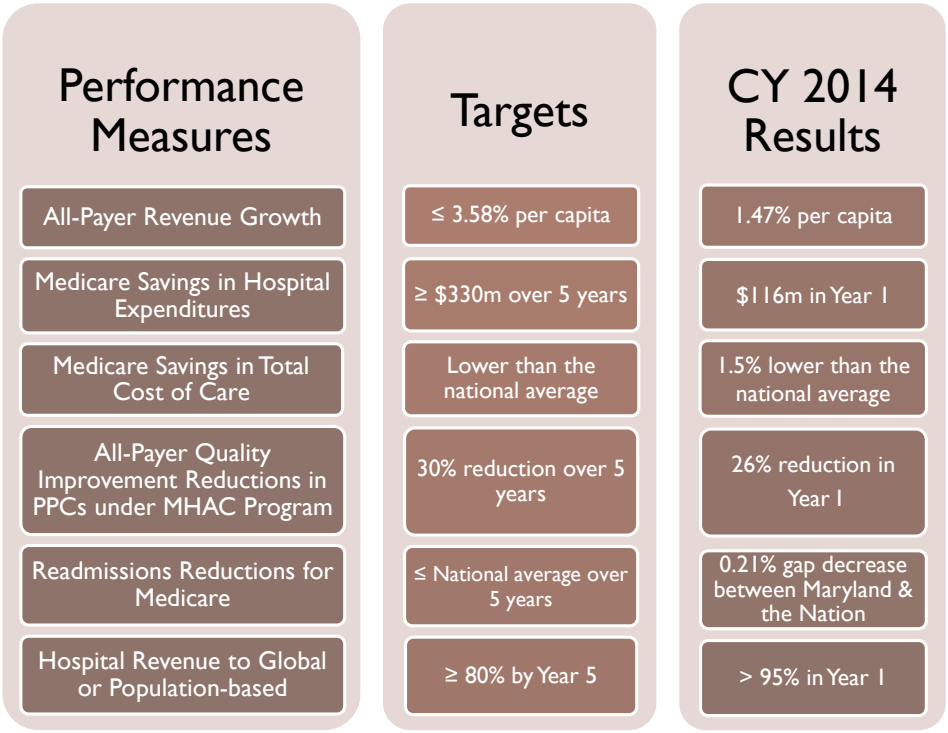
Volume Changes

The HSCRC staff has been paying attention to volume changes in hospitals. A core approach for the success of the All-Payer Model is to reduce unplanned hospitalizations that could be avoided with better care, care coordination, and care integration. By reducing avoidable utilization, funds are freed up to allow for investing in care coordination, delivering new services, and implementing other initiatives. We are also attentive to Medicare growth in charges and utilization as the All-Payer Model has specific savings requirements for Medicare.

HSCRC staff will provide reports on utilization trends to the Commission on a regular basis.

Year 1 Results

Last week, CMS released the Year 1 (CY 2014) results for Maryland's All-Payer Model. The results were as follows:



Maryland had a good first year of performance, but there is significant work ahead to ensure the sustainability and progression of the model and targeted improvements.

Planning for Ongoing Implementation and Application to Extend the All Payer Model

With the State's new All-Payer Model nearing its second full year of operations, the Department of Health and Mental Hygiene (DHMH) and the Health Services Cost Review Commission (HSCRC) are reconvening the Advisory Council. The Council, originally charged with recommending guiding principles for the implementation of the new model, is now needed to provide advice on the potential future directions for Maryland's health care improvement and population health initiatives and the All-Payer Model progression. In order to create sustainability of the existing All-Payer model, the delivery system needs to develop partnerships and infrastructure that will help it improve care with a resulting reduction in avoidable hospitalizations and costs. Additionally, the Agreement between the Centers for Medicare & Medicaid Services (CMS) and Maryland calls for Maryland to submit a proposal for a new model no later than January 2017, which shall limit, at a minimum, the Medicare beneficiary total cost of care growth rate. HSCRC staff is engaged in a planning process with stakeholders to prepare for these upcoming meetings.

The HSCRC and DHMH staff members are also working with the Center for Medicare & Medicaid Innovation (CMMI) to amend the existing All-Payer Model Agreement to allow for alignment activities needed to support successful implementation and sustainability of the model. To support these integration components, tools that are available to Accountable Care Organizations (ACOs) and bundled payment programs need to be made available to support the integration and care coordination activities needed. These include:

- Sharing internal cost savings
- Pay-for-outcomes programs that share internal cost savings when avoidable and unnecessary utilization is decreased through improvements in care delivery; and
- Investments in care coordination infrastructure that support care coordination in the community, some of which may be imbedded in practices or other provider settings

To facilitate these activities, the model will need to be enhanced to provide protections similar to those granted to ACOs that permit these activities. In addition, staff will seek access to data to support care coordination, evaluation, and monitoring of results by providers, similar to data provided by CMS to ACOs and bundled payment providers.

DHMH is also considering the development of an approach to address the needs of dual eligible beneficiaries (those who have both Medicare and Medicaid coverage). This process will be organized together with Work Groups for the All-Payer Model since the work needs to be integrated.

Finally, HSCRC has issued an RFP for assistance with development of the proposal of a new model. It is in the process of evaluating proposals, together with members of the leadership staff of DHMH and MHCC.

Regulations on Rate Application Moratorium

Staff is proposing a regulation to establish a temporary moratorium on full rate reviews. The regulation is necessitated by the fact that the Commission's current policy does not adequately reflect the existing global budget revenue structure that all acute care hospitals are currently under. As hospitals reduce potentially avoidable utilization (PAU) through care and quality improvements, unit costs may rise. Under the existing Reasonableness of Charges (ROC) methodology, such an increase may increase the charge per case. This would contribute to creating a higher charge per case benchmark as volumes fall. HSCRC would want to remove the excess capacity and isolate the investment cost to produce the savings level in calculating an efficient hospital operating cost benchmark. The opposite is true if a hospital were to experience an increase in PAU. The hospital could appear to be more efficient as its charge per case decreases, even though it would not be meeting the goals of the model. Staff has begun

working on new efficiency measures that aim to balance the goals of the All-Payer Model three-part aim with operating efficiency concepts.

Previously the Commission issued a moratorium of full rate reviews for three years to accommodate the development and coding changes necessary to implement APR-DRGs. This regulation anticipates a much shorter moratorium while new efficiency measures are being developed. We are targeting completion by July 2016.

Staff will continue to evaluate capital applications under the current approach. However, we will consider changes in PAU when evaluating efficiency changes beyond 2014. At the current time, we are continuing to use a 2014 ROC calculation.

Hospitals will continue to have all other rate relief approaches at their disposal.

Extension of the Submission Date for Transformation Implementation Submissions

Staff has received multiple requests from hospitals to extend the submission date of the Transformation Implementation Program applications for two weeks. In order to give hospitals more time to refine the proposals, the staff has extended the submission date from December 7, 2015 to December 21, 2015.

The reports of Regional Partnership Planning Grantees that received funding through rates in June 2015 are still due on December 7, 2015. Likewise, the Strategic Hospital Transformation Plans are due from all acute care hospitals on December 7, 2015. An updated Request for Proposal (RFP) for the Transformation Implementation Program and related Q&A may be found on the Commission website.

Staff Focus

HSCRC staff is currently focused on the following activities:

- Continuing to review radiation therapy, infusion and chemotherapy market shift adjustments with stakeholders.
- Reviewing Certificate of Need (CON) applications that have been filed. Staff has recently provided comments to MHCC regarding two applications.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Turning to focus on per capita costs and total cost of care, for purposes of monitoring and progressing toward a focus on outcomes and cost across the health care system.

- Preparing to finalize and support a stakeholder process that will be executed together with DHMH and other agencies. It will be focused on ensuring the success of the All-Payer Model and providing a proposal no later than January 2017 as required under the All-Payer Model Agreement with CMS.

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

Memorandum

Date: November 6, 2015

To: Frances B. Phillips
Commissioner/Reviewer, MHCC

From: Gerard J. Schmith
Deputy Director, Hospital Rate Setting, HSCRC

Subject: Relocation of Washington Adventist Hospital ("WAH") and Establishment of a Special Psychiatric Hospital on the Existing Takoma Park Campus
Docket No. 13-15-2349

On August 31, 2015 you requested that we review and comment on the financial feasibility and underlying assumptions of the relocation of WAH from its existing location in Takoma Park to the White Oak area and establishment of a Special Psychiatric Hospital on the existing Takoma Park Campus. Adventist HealthCare Incorporated, ("AHI"), the owner and operator of WAH, submitted an amended CON on September 29, 2014 with additional supplemental information including a letter dated July 27, 2015 from James Lee, Executive Vice President and CFO of AHI.

This memorandum provides our general comments and addresses your specific questions regarding the project.

General Comments on Financial Feasibility

Data Reviewed

We reviewed the revised financial portions submitted on October 21, 2015 as well as other pertinent supplemental information associated with the CON provided by WAH prior to that date. The information submitted included audited financial data for the fiscal years ending December 31, 2013 and 2014, actual and budgeted data for fiscal year ending 2015, and projected data for the fiscal years ending 2016 through 2020 (the second full year after the completion of the project.)

Along with these financial projections, we have also reviewed WAH's audited financial statements for the year ended December 31, 2014 and the expected financing plan for this project.

Revenue Projections

We have reviewed the assumptions regarding the projections of operating revenue. The assumed annual HSCRC approved revenue increases listed in the CON assumptions provided by WAH that were the basis for the revenue increases shown in the table below are as follows:

Table 1 - Summary of Projected HSCRC Approved Revenue Increases
Washington Adventist Hospital

	Years Ending June 30,					
	2015	2016	2017	2018	2019	2020
Update Factor	2.21%	2.17%	2.30%	2.30%	2.30%	2.30%
Age Adjusted Population Growth	0.00%	.56%	.56%	.56%	.56%	.56%
Population Infrastructure	0.00%	1.05%	0.00%	0.00%	0.00%	0.00%
Market Shift	0.0%	.23%	0.00%	0.00%	0.00%	-.05%
Other Reversals, One Time Adj, etc.	-.75%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	1.46%	4.01%	2.86%	2.86%	2.86%	2.81%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

In addition to the revenue increases shown above, WAH assumed that revenue would increase by $15,391,282 (5.4%) on January 1, 2019 to reflect the HSCRC approved capital increase.

Staff believes that the assumed increases are reasonable in light of the projected changes in population and approved revenue.

WAH projected that charity write offs would equal 6.5% of gross patient revenue from 2015 through 2020, an increase of .5% from the 2014 actual 6.0%. WAH projected that bad debt expenses would equal 5.0% of gross patient revenue less Uncompensated Care Fund payments from 2015 to 2020, which represents a 1.7% decrease from the 2014 actual of 6.7%. WAH attributes these changes to the changes brought about by the Affordable Care Act.

WAH's actual other deductions from revenue equaled 11.8% of gross patient revenue in 2014. WAH projected that its other deductions from revenue would decrease to 9.5% of gross patient revenue in 2015, decreasing to 9.4% from 2016 through 2018, and then decreasing to 9.3% in 2019 and 2020. WAH attributes this improvement to engaging a revenue cycle management firm to manage the revenue cycle operations and the reduction in HSCRC assessments due to the elimination of the Maryland Health Insurance Program (MHIP).

The HSCRC staff also reviewed WAH's projections of other operating revenue. The projected other operating revenue is considered reasonable and achievable. WAH did not project any non-operating revenue associated with this project.

Expense Projections

Staff reviewed the assumptions regarding the projection of expenses. WAH stated that it applied the following variable expense change assumptions in the CON projected financial statements

Table 2 - Summary of Assumed Expense Increases
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31,					
	2015	2016	2017	2018	2019	2020
Salaries Excluding Overhead:						
Inflation	2.3%	2.2%	2.3%	2.2%	2.3%	2.2%
Change in FTE's	2.0%	1.8%	-.2%	-.4%	1.8%	.8%
Supplies Excluding Overhead:						
Inflation	8.2%	2.0%	3.5%	3.5%	3.5%	3.5%
Volume	-.4%	1.8%	0.4%	-.1%	.7%	1.2%
Contract labor Excluding Overhead:						
Inflation	2.3%	2.2%	2.3%	2.2%	2.3%	2.2%
Change in FTE's	17.1%	-12.5%	-.2%	-.4%	1.8%	0.0%
Purchased Services Excluding Overhead:						
Inflation	-10.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Volume	2.6%	0.0%	0.0%	0.0%	-.2%	.7%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

For fixed expenses, WAH assumed a series of inflation factors for 2016 to 2020 ranging from 0% for professional fees to 2.5% for administrative and general expenses. For 2015 inflation, WAH assumed 0.0% for professional fees, 11.5% for building and maintenance expense, negative (1.9%) for the overhead allocation from AHI, a negative (.2%) for general and administrative costs, and a negative (7.7%) for insurance costs.

WAH assumed that it would reduce building and maintenance operating costs by 20%, or approximately $1,800,000, after the move to the new White Oak facility. WAH has stated that it will contract with an unrelated party to provide utility services to the new White Oak facility through a Centralized Utility Plant (CUP).

WAH is projecting that its number of FTE's per Average Equivalent Occupied Beds (AEOB) will increase from an actual 4.1 in 2014 at the existing WAH facility to a projected 4.7 in 2020 at the new White Oak facility. The reason for the large increase in projected FTE's per AEOB is due to the fact that approximately 16% of WAH's patient days are related to the psychiatric patients who will remain at the existing WAH facility. The 2014 FTE's per AEOB for other neighboring Montgomery and Prince Georges County hospitals range from 5.0 at Montgomery General Hospital to 5.8 at Prince Georges General Hospital. Part of the reason for WAH's lower FTE's per AEOB is due to the fact that WAH does not report FTE's for all of the shared services that it purchases from AHI including patient billing and Information Technology Services.

Staff calculated the projected overall annual expense percentage variability with volume based on the percentage change in uninflated revenue compared to the annual change in total expenses including depreciation and interest depreciation and interest. The results of staff's analyses were as follows:

Table 3 – Projected Expenses Percent Variability with Volume
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31,				
	2016	2017	2018	2019	2020
Including Depreciation and Interest	104.0%	14.2%	97.3%	-11.8%	97.2%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

The average variable cost change averages approximately 90% over the 5 year period. However, since the overall volume change is very small during this period, any change to the variable cost percent would have little impact on the overall projection of expenses. Staff believes that the assumptions used in the projections of ongoing annual expenses are reasonable and achievable.

In the project budget for capital expenses, WAH made an assumption that it would incur $2,700,000 in relocation costs for the move of the medical/surgical and obstetrics units and practically all outpatient services at the old facility to the new facility. The $2,700,000 estimated relocation costs seem low. WAH may incur cost at the new facility before it opens related to training, staffing, inventories, food, and other items related to relocation. There may also be transportation costs of moving patients and staff from the old facility to the new facility. If WAH needs to maintain some of the medical/surgical and obstetrics units and practically all outpatient services at the old facility after the new facility is open, then costs may be higher than the $2,700,000 WAH has projected.

Financial Ratios

WAH states on Page 128 of the CON that AHI will secure financing for the project pursuant to its amended and restated master trust indenture dated February 1, 2003. WAH provided the projected financial information and ratios for the obligated group of AHI. On a consolidated basis AHI projects that it will meet the ratio levels required under its bond documents.

Listed below are the AHI projected ratios and the required ratios per the bond covenants provided by WAH:

Table 4 - Adventist HealthCare Obligated Group Key Financial Information and Ratios
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31, (in millions)							
	2013	2014	2015	2016	2017	2018	2019	2020
Operating Income	$8.7	$22.5	$34.4	$32.7	$28.4	$29.1	$17.4	$16.0
Operating Margin	1.2%	3.1%	5.1%	4.8%	4.1%	4.1%	2.4%	2.1%
Excess of Revenue over Expenses	$12.1	$25.8	$42.7	$41.8	$37.8	$38.7	$27.2	$25.9
Excess Margin	1.7%	3.5%	6.3%	6.1%	5.5%	5.5%	3.7%	3.4%
Operating Cash Flow	$54.2	$71.1	$74.7	$74.5	$70.9	$72.5	$87.4	$87.9
Operating Cash Flow Margin	7.7%	9.7%	11.1%	10.9%	10.3%	10.3%	11.8%	11.6%
Debt Service Coverage-Projected	1.80x	2.13x	2.39x	2.08x	2.00x	2.04x	2.52x	2.79x
Debt Service Coverage --Required	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x
Cash and Equivalents	$225.9	$245.1	$213.5	$226.4	$230.3	$196.3	$212.7	$229.2
Days Cash on Hand –Projected	124.6	132.4	127.8	133.8	133.2	111.1	114.8	120.6
Days Cash on Hand-Required	70	70	70	70	70	70	70	70
Long Term Debt	$321.2	$319.8	$299.2	$523.5	$504.7	$502.7	$482.7	$464.1
Net Assets	$396.0	$419.0	$432.8	$480.4	$519.8	$575.4	$587.5	$604.0
Debt to Capitalization-Projected	44.8%	43.3%	40.9%	42.1%	49.3%	46.6%	45.1%	43.4%
Total Liabilities to Unrestricted Net Assets-Projected	1.23x	1.15x	1.03x	1.38x	1.22x	1.11x	1.07	1.03
Total Liabilities to Unrestricted Net Assets-Required	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x

Source: Data Provided by WAH on November 2, 2015

Based upon these projected ratios, Staff believes that AHI would be able to obtain financing for the project on terms that are consistent with those assumed in the plan of finance.

Projected Volumes

Even though hospital global budgets are fixed and are not sensitive to volume, Staff is concerned about potential declines in volumes that may occur as care models are changed and as population health is improved. Even without these initiatives, there has been a steady decline in inpatient hospital utilization over decades, in spite of an aging population. The introduction of DRGs, technological advances in surgery, radiation therapy, and new medications have contributed to this change. While costs have not decreased, services have moved to outpatient settings. Nationally and in Maryland, payment and delivery models are changing. These models are likely to accelerate these trends toward lower inpatient utilization. Our advice is that attention should be directed to making sure that bed need projections account for these trends and changes while the State is evaluating the size of the facility. There is a risk that excess capacity could develop, and that this excess capacity could affect the feasibility of the WAH project. For example, several of the TPR hospitals saw intensive inpatient volume decreases resulting in excess capacity, including capacity in new facilities.

One measure of the potential for utilization to fall is Potentially Avoidable Utilization (PAU). This is a measurement of categories of unplanned hospital utilization that can be reduced through better care, better care coordination, and other interventions. Staff is measuring several categories of PAUs. Not all PAUs are avoidable, but Staff has not yet identified all categories of utilization that are avoidable. Staff is currently working with recognized national experts to add to the categories of avoidable utilization.

In HSCRC's recent calculations of PAUs used to update statewide revenues as of July 1, 2015, WAH's percentage of PAU's was 16.47% versus a statewide average of 13.65%. This comparison of PAU's has not yet been adjusted for socioeconomic status or other health disparities. In the most recent ROC calculations, WAH had 29.3% of its patients classified as disproportionate share (poor patients) compared to an average of 17.8% for the total hospitals in its comparison group. WAH's significantly higher than average percentage of disproportionate share patients is likely contributing to its higher than average percentage of PAU's.

On a combined basis, the hospitals in Prince Georges County had 18.50% of their patients classified as PAU's, while Montgomery County hospitals had 14.43% of their patients classified as PAUs. Therefore, not only does WAH have a high proportion of PAU's but the hospitals surrounding WAH also have high proportions of PAU's. Staff believes th potential for volume declines in WAH's service area related to future reductions in PAUs should be considered when evaluating bed need projections as potentially affecting feasibility. We understand that MHCC carries the responsibility for this effort and that it is difficult to predict the exact impact of change. Nevertheless, Staff believes conservatism is warranted. WAH is projecting the following discharges and observation patient volumes for CYs 2015 through 2020:

Table 5 – Projected Volumes
Washington Adventist Hospital Revised CON Projections

	Year Ended December 31,						
	Actual	Projected					
	2014	2015	2016	2017	2018	2019	2020
Inpatient Discharges Excl. Psych.	9,892	9,131	9,558	9,567	9,576	9,672	9,768
Outpatient Observation Patients	1,185	2,299	1,881	1,881	1,881	1,900	1,919
Totals	11,077	11,430	11,439	11,448	11,457	11,572	11,687

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

Included in WAH's construction plans are 8 dedicated Short Stay Observation Beds in the lower tower and 12 Clinical Decision beds adjacent to the Emergency Department for a total of 20 additional beds to treat patients classified as observation patients. WAH is projecting 76,132 observation hours in 2020, the second year of operations at the new White Oak facility. Dividing these hours by 24 hours per day results in 3,172 days of observation care, or an average daily census of 8.7 patients. Many patients stay less than 24 hours, so we are not certain how this translates into bed need or occupancy.
Adding the 20 observation beds to the 152 proposed medical surgical (MSGA) beds results in a total of 172 beds to take care of patients requiring inpatient MSGA services at the new White Oak facility. Adding the projected 3,172 observation patient days to the projected 41,763 MSGA days projected

for 2020 results in a total of 44,935 patient days to be treated in the 172 total MSGA beds for an average occupancy rate of 71.6% in 2020. For the 152 proposed MSGA inpatient beds only, WAH is projecting an occupancy rate of 75.3% in 2020. The State Health Plan calls for a minimum occupancy level of 80% for hospitals with 100 to 299 medical surgical beds. The use of all private rooms may increase the level of occupancy that can occur. We understand that MHCC will evaluate occupancy in its review of bed need.
Staff is concerned about future inpatient volume levels in the service area. If WAH is unable to achieve the projected volumes, the Hospital would be less efficient and would have higher rates, which in turn could affect the overall feasibility of the project. In summary, Staff is suggesting that conservatism in bed need projection is warranted relative to project feasibility and efficiency, given the level of change in the delivery system that is underway nationally and in Maryland.

Responses to Specific Questions:

1. Are the sources of funds assumed by the applicant appropriate? In your opinion, is the equity contribution and the proportion of other non-debt sources of project funding adequate?

WAH intends to finance the total project costs of $330,829,524 by incurring $244,750,000 in debt, fund raising $20,000,000, contributing cash of $50,575,175, and earning $4,504,349 in interest income during construction. All of the $330,829,524 project cost is related to capital costs with no allowance made for working capital costs or transition costs.

In addition to the $20,000,000 assumed fund raising and $50,575,175 cash contribution, WAH is assuming that the $11,000,000 previously expended for the purchase of the land for the project will also be a source of funds leaving the total equity contribution at $81,575,175, or approximately 25% of the project costs.

Staff spoke with representatives of the Maryland Health and Higher Educational Facilities Authority (MHHEFA) who stated that AHI has a Baa2 debt rating. WAH has assumed an interest rate of 6% for the debt associated with this project, which seems to be high given current interest rates. If the actual interest rate is less than that assumed, the rate adjustment approved by the HSCRC would be modified to reflect the lower interest rate.

Additionally, while the estimated annual depreciation, amortization, and interest is $24.6 million, the HSCRC only approved an additional $15.4 million revenue increase. Therefore, AHI will be financing a significant portion of the borrowing.

Given AHI's debt situation, staff believes that WAH has provided a reasonable amount of equity contribution for the project to be financially feasible. Ideally staff would like to see higher equity contributions so that the interest rate might be lower on the debt issued for the project resulting in overall lower costs to the patients.

2. As you know, one of the applicant's assumptions is that it will obtain a 7% increase in the hospital's global budget revenue to account for the increased capital costs resulting from this project. In your opinion, is this increase necessary for this project to be feasible and for the replaced and relocated WAH to be financially viable? If, in your opinion, this increase is not

necessary for project feasibility and the viability of WAH, please provide the basis for this opinion.

The 7.0% rate increase assumed by WAH represents approximately 80% of the additional depreciation and interest related to the new project. As stated above, Staff has recommended a $15.4 million (5.4%) increase to revenue instead of the 7.0% requested. WAH had used projected operating results for FY 2014 in its original CON submission. Its actual operating results for that year were much better than projected. These results were incorporated in its projections submitted on October 21, 2015. This improvement significantly offsets the impact of the lower approved revenue increase.

3. Based on your analysis and the experience of HSCRC to date in implementing the new payment model for hospitals, what is the ability of the proposed replacement hospital to be competitively priced, when compared with general hospitals in its region of the state and when compared with similar (peer-group) hospitals throughout the state, if the project is implemented as proposed and the applicant's utilization projections are realized?

Competitive rates for proposed hospital – In order to evaluate the proposed rates of the relocated hospital, we developed a comparison of how WAH's inpatient and outpatient hospital charges compared to its local competitors for the year ended June 30, 2014. Staff's analyses compared average inpatient charges per case by APRDRG broken down between the 4 severity levels within each APRDRG. Staff's analyses also compared average outpatient charges per case broken down by APG.

Listed below are the percentage variances between WAH's average charges per inpatient case and outpatient case and its neighboring hospitals for the year ended June 30, 2014:

Table 6
Comparison of Average Inpatient and Outpatient Charges per Case
Washington Adventist Hospital and Neighboring Competitors
Using Actual Charge Data
Year Ended June 30, 2014

Hospital	Percent Variance from WAH Average Inpatient Charges per Case	Percent Variance from WAH's Average Outpatient Charges per Case	Combined Percent Variance from WAH's Average Charges per Case
Doctors Hospital	(8.4%)	(4.3%)	(7.5%)
Howard County	(13.6%)	(21.9%)	(17.9%)
Montgomery Medical Center	(13.1%)	(8.4%)	(12.3%)
Suburban Hospital	(18.4%)	(4.3%)	(14.4%)
Holy Cross Hospital	(14.1%)	(7.8%)	(12.8%)
Laurel Regional Medical Center	(12.0%)	6.6%	(5.7%)
Average Difference	(13.3%)	(6.1%)	(11.6%)

Source: HSCRC Market share data base. Percentages were determined by first comparing to statewide averages and then comparing to WAH variances from statewide average.

As this table indicates, the charges at WAH's competitors were on average 13.3% below WAH's charges for inpatients and 6.1% below for outpatients based on actual charge data for the year ended June 30, 2014. Once WAH is granted an additional 5.4% rate increase for capital its competitors will have rates on average that may be more than 15% less than WAH's new rates based on the comparisons of actual FY 2014 charges. However, these comparisons do not take into account the cost differences that may be attributable to taking care of populations with lower socioeconomic status. The ROC comparison discussed below includes an adjustment to estimate the impact on costs of these population differences.

Staff compared adjusted charges using information from the most recent ROC calculation, which utilized data from 2013 adjusted for revenue changes to 2014. The adjusted charge comparison from the ROC data is as follows:

Table 7
Comparison of Average Combined Inpatient and Outpatient Charges per Case
Washington Adventist Hospital and Neighboring Competitors
Using Adjusted ROC Charges
Year Ended June 30, 2014

Hospital	Percent Variance from WAH's Average Combined Adjusted Charges per Case
Doctors Hospital	12.5%
Howard County	.5%
Montgomery Medical Center	10.4%
Suburban Hospital	9.9%
Holy Cross Hospital	(9.5%)
Laurel Regional Medical Center	(6.4%)
Average Difference	7.5%

Source: HSCRC ROC data. Percentages were determined by first comparing to statewide averages and then comparing to WAH variances from statewide average.

As noted above, the ROC analysis takes into account that WAH has a greater percentage of poor patients than the average of the hospitals in its peer group, which tends to cause higher costs and rates.

Other requests:

You also asked to receive comments on the financial feasibility of providing acute psychiatric hospital services in Takoma Park as a 40-bed special hospital. The project budget, five year pro forma schedule of revenues and expenses, and assumptions for this proposed special hospital

were submitted on December 12, 2014. Note that the project budget erroneously indicated that the source of funds for renovating space for behavioral health would be cash. The correct source of funds is debt, as specified in Exhibit 6 of the September 29, 2014 replacement application. This was confirmed by WAH in its response to my April 29, 2015 request for additional information.

Financial Feasibility of 40 bed special psychiatric hospital on Takoma Park campus.

Staff reviewed the pro forma income statement provided by WAH in the December 12, 2014 supplemental submission letter for the 40 bed psychiatric unit that will remain at WAH after the relocation of the other beds to White Oak. The 40 bed unit will be owned and operated by Adventist Behavioral Health (ABH), a psychiatric specialty hospital owned by AHI that is located in Rockville Maryland. The pro forma is only for the 40 bed psychiatric unit and does not include any information on the other services that will exist at WAH after the relocation such as the 24-hour urgent care clinic and the Women's Health Clinic.

On August 24, 2015, the Maryland Medicaid program reduced reimbursements to free-standing psychiatric facilities larger than 16 beds because CMS withdrew a waiver that had been approved for the State of Maryland, which had allowed Maryland Medicaid to reimburse these facilities for acute psychiatric services. Maryland's Department of Health and Mental Hygiene is currently seeking a new federal waiver that would significantly expand the scope of treatment options available to Medicaid enrollees with substance abuse and mental health disorders. WAH provided documentation showing that ABH has not been impacted by the reduction in Medicaid reimbursement, and that WAH, for a variety of reasons including the pending new waiver request, does not anticipate any reduction in projected Medicaid payments for the 40 bed psychiatric unit remaining in Takoma Park. Staff believes that the projected net revenues for the 40 bed psychiatric unit are reasonable, assuming that Medicaid does not reduce payments to free-standing psychiatric hospitals in the future.

Staff performed reasonableness tests of the direct costs for salaries and benefits and other expenses included in the December 12, 2014 pro forma for the 40 bed psychiatric unit. Staff compared the projected 2019 costs per patient day in the pro forma to the regulated costs per patient day that ABH incurred during the year ended December 31, 2014 based on ABH's HSCRC Annual Report provided to the HSCRC. Staff inflated the actual ABH expenses for the year ended 2014 by 2.3% per year to 2019 based on the inflation assumptions included in WAH's CON.

The results of staff's analysis are presented below:

Table 8 - Comparison of Projected Takoma Park Psychiatric Unit Costs to Adventist Behavioral Health Actual Costs on a per Equivalent Inpatient day Basis

	Cost per Equivalent Inpatient Day		
Expense Category	Takoma Park Psychiatric Unit Projected FY 2019	Adventist Behavioral Health YE 12/31/2014 Inflated to 2019	Percent Variance
Salaries and benefits	$574	$600	4.5%
Depreciation and interest	186	27	(85.5%)
Other	352	229	(65.1%)
Total Costs	$1,112	$837	(24.7%)
Equivalent inpatient days	10,578	32,467	

Sources: HSCRC Annual Report for the Year Ended December 31, 2014 and additional WAH CON information submitted December 12, 2014.

Although Staff would expect that there would be economies of scale causing lower salary and benefits per patient day at ABH than at the Takoma Park site, the overall expenses per day appear reasonable. Staff believes that ABH's management team will be able to bring cost in line where appropriate.

The income statements in the CON include projected net income of $5,465,000 in 2019 and $6,897,000 in 2020 for the new White Oak facility. The pro forma for the 40 bed psychiatric unit included a $210,000 projected profit in the first year of operations after the White Oak facility opens. The projected income statements provided by WAH in the July 27, 2015 letter from James Lee for both the White Oak facility and the services remaining at WAH show projected net income of only $747,000 in 2019 and $1,770,000 in 2020. The approximate annual $5,000,000 difference between the two sets of projected financial statements represents the annual projected loss on the other services that will remain at Takoma Park.

Staff reviewed additional information provided by WAH regarding the projected financial operations of services remaining at Takoma Park. This financial information appears reasonable.

Finally, you asked that we comment on Laurel Regional Hospital's and MedStar Montgomery Medical Center's submission of an analysis of the impact of the relocation on their discharges and the impact of such a reduction in volume on their revenues and bottom line profit. While you did not necessarily agree with the hospitals' assessments of the impact on volume and you did not ask for our opinion on their calculation of the expected loss in discharges, you did ask for our comments on the methodology used to convert such losses in volume to reductions in revenue and impact on the hospitals' bottom line profit (the relevant analysis submitted by the interested parties on May 29, 2015 was attached).

Laurel Regional Hospital and MedStar Montgomery Medical Center Comments

The major issue with the analysis prepared on behalf of Laurel Regional Hospital (LRH) and MedStar Montgomery Medical Center (MMC) is that LRH and MMC are projecting a far greater number of discharges moving from their facilities than WAH has projected. WAH is projecting that 95 discharges will move to their new White Oak facility from LRH, while 91 discharges will move from MMC to the new White Oak facility. LRH is projecting that it will lose 582 discharges to the new WAH facility at White Oak. MMC is projecting that it will lose 284 discharges to the new WAH facility.

Assuming that all of LRH's and MMC's assumptions regarding revenue, collection percentages, and variability of expenses are accurate, but substituting WAH's projected changes in discharges, the estimated impact at LRH would then decrease from ($1,123,000) annually to ($183,000.) At MMC, the impact would be reduced from ($952,000) annually to ($305,000) if WAH's projected changes in discharges are accurate.

Another less important issue is the assumption of variability in expenses for supply and drug costs. Both LRH and MMC assume that supply and drug costs would vary at a 60% rate with changes in volumes. Normally supplies and drugs should vary at or near 100% with changes in volumes. Assuming a higher variability factor for supplies and drugs would also reduce the projected impact on LRH and MMC.

We also note that the submission by LRH may be irrelevant, given its recent announcement of facility reconfiguration and plans to eliminate much of the acute inpatient capacity of the hospital.

Summary

Staff believes that the overall assumptions regarding the financial viability of the new facility at White Oak are reasonable and achievable depending on WAH attaining the volumes projected in the CON. The current environment of change in health care financing and delivery increase the probability that inpatient volumes will decline. WAH and the surrounding hospitals in the area presently have substantial volumes of f PAUs. Staff recommends conservatism in evaluating need. If WAH does not attain the projected volumes in the CON its overall rate and revenue structure may be viewed as inefficient and may affect the overall financial viability of the project.

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

Memorandum

Date: October 23, 2015

To: Robert E. Moffit, Ph.D.
Commissioner/Reviewer, MHCC

From: Gerard J. Schmith
Deputy Director, Hospital Rate Setting, HSCRC

Subject: Relocation of Prince George's Hospital Center ("PGHC")
Docket No. 13-16-2351

This Memorandum is in response to your memo dated September 11, 2015 regarding the Certificate of Need ("CON") filed by Dimensions Health Corporation ("DHC") and Mount Washington Pediatric Hospital to replace and relocate PGHC. A 15-bed Special Hospital-Pediatric is operated by Mount Washington Pediatric Hospital, Inc. ("MWPH") within leased space at the current PGHC, and this facility would also be replaced as part of the proposed project and operated under the same arrangement.

The estimated project cost for the relocation and replacement of the general hospital and the special hospital-pediatric is $651,223,000. Dimensions proposes to finance the relocation of the hospital to Largo with approximately $206.7 million in debt, grants of $208 million from the State of Maryland and $208 million from Prince George's County, and a total of $16.1 million in interest income from bond proceeds. $12.4 million is the recognized value of the donated land within this project cost estimate.

You requested that HSCRC staff review the financial projections and the assumptions upon which these projections are based, as provided in the March 13, 2015 revisions to the January 16, 2015 replacement CON application (Exhibit 50, Tables G1 and H1), and comment on the proposed project's financial feasibility and the reasonableness of the assumptions.
You also requested that we provide comments on these specific questions:

1. Are the sources of funds assumed by the applicants appropriate? In your opinion, is the proportion of non-debt and non-grant sources of project funding adequate?

2. The applicants have assumed that a 7.6% increase in the hospital's global budget revenue ("GBR") will be obtained to account for the increased capital costs resulting from this project. In your opinion, is this increase necessary for this project to be feasible and for the replaced and relocated PGHC to be financially viable? If, in your opinion, this increase is not necessary for project feasibility and the viability of PGHC, please provide the basis for this opinion.

3. Based on your analysis and the experience of HSCRC to date in implementing the new payment model for hospitals, what is the ability of the proposed replacement hospital to be competitively priced, when compared with general hospitals in its region of the state and when compared with similar (peer-group) hospitals throughout the state, if the project is implemented as proposed and the applicants' utilization projections are realized?

4. Dimensions is assuming an increase in its GBR in each of the first three years of operation of the replacement hospitals resulting from market share shifts. A revenue increase of 2.91% is projected for FY 2020, 2.75% for FY 2021, and 2.61% for FY 2022. Based on your analysis and the experience of HSCRC to date in implementing the new payment model for hospitals, what would be the impact of Dimensions not achieving these market shifts on the financial viability of the relocation and the ability of the proposed replacement hospital to be competitively priced, when compared with general hospitals in its region of the state and when compared with similar (peer-group) hospitals throughout the state.

5. Dimensions also assumes that revenue adjustments for market share shifts would be recognized immediately in the year of the volume growth resulting from the shift in market share rather than in the year following the volume growth. In commenting on the financial feasibility of the project and the viability of PGHC after relocation, please indicate whether HSCRC will agree to this treatment of market share shift-related volume increases. If HSCRC will not agree to this, please address the impact on feasibility and viability and any impact on the size of the global budget adjustment for capital. (See Dimensions' March 13, 2015 response to Question 22 of MHCC staff's February 10, 2015 completeness letter (page 31).

HSCRC Staff has done an initial review of Prince George's Hospital Center's CON and current financial situation including its overall rate structure. At this time, HSCRC Staff does not believe it has the data needed to perform an in-depth analysis of the PGHC CON. For instance, we note that a substantial difference exists between actual operating profit for FY 2014 included in the CON financial projections and the actual operating profit from the Audited Financial Statements for FY 2014. However, Staff makes the following comments at this time regarding the questions you have posed:

1. The only sources of fund which are non-debt and non-grant are the $16.1 million interest income from bond proceeds and the $12.4 million recognized value of the donated land. We have not received a copy of DHC's projected plan of finance; therefore, we cannot render an opinion on the $16.1 million, nor have we received an appraisal of the value of

the donated land. According to the CON, DHC will need to borrow approximately $77 million at the opening of the new facility in order to ensure that it maintains 100 days of cash on hand. Therefore, DHC has no cash available to help fund the project.

2. The CON includes an assumption that the HSCRC would approve a $21.5 million (7.0%) increase to its approved revenue after the facility opens. This increase represents 50% of the estimated additional depreciation, interest, and amortization related to this project. As of this date, PGHC has not filed a rate application with the HSCRC requesting any type of rate increase. Without a rate application, Staff cannot determine if this contemplated rate increase is justified. We have completed a pro forma analysis of our current policy, which permits a hospital to request additional revenue related to a major CON approved project. [1] The pro forma analysis does not produce any increase for additional capital for PGHC.

3. The latest Reasonableness of Charges ("ROC") calculation shows that PGHC is more than 14% above the average adjusted charges of its comparison peer group and nearly 10% above adjusted average State-wide charges. PGHC's unadjusted charge difference for FY 2014 would be even greater. The Hospital needs to achieve significant productivity improvements to improve its ROC position. In the CON application, it proposes to do that through increasing its volumes at 50% variable cost. The volume increase assumption creates a risk to competitiveness of rates if the volume increases are not achieved. Additionally, the Hospital has not yet demonstrated the capability to deliver the incremental services at 50% variable cost. This creates a second risk of whether the Hospital will be able to produce the services at 50% variable cost should the volumes increase.

4. Staff is uncertain at this time as to the impact of the downsizing of Laurel Hospital on PGHC's projections. The CON filed by PGHC did not take into account the impact of the downsizing of Laurel Hospital which, staff believes, should have a positive impact on PGHC's future financial projections. Laurel Hospital had significant declines in utilization, which resulted in losses. Addressing these losses and bed need in more comprehensive ways given declines in inpatient services should strengthen the viability of service offerings in Prince Georges County. We have read the recommendations provided to Laurel Hospital by their consultants. We stand prepared to review any additional information that is provided regarding future service reconfigurations as they evolve, recognizing that the environment is changing rapidly with consumer driven health

[1] This is the same analysis that formed the basis of the HSCRC's approval of $15.3 million for additional capital when Washington Adventist Hospital's ("WAH's") new facility opens. The HSCRC rate increase to WAH is contingent on MHCC's final approval on WAH's CON project.

care transformation and increased emphasis on outpatient, telemedicine, retail, and virtual service delivery.

5. PGHC has not requested any deviation from HSCRC's normal methodology regarding the treatment of market shift adjustments. In the case of the new Holy Cross Germantown facility, for example, the HSCRC permitted an adjustment for market share to occur as volumes increase. HSCRC Staff has not yet determined whether the adjustment would apply in this circumstance. To make that determination, we will need additional information from PGHC.

As to the methodology used by Doctors Hospital to convert volume losses to revenue reductions, we believe that while the method may produce a reasonable 'ballpark' estimate of lost revenue, the actual amount would most certainly be impacted by the types of lost cases. Additionally, Doctors' estimates of the impact on expenses and operating profits are questionable.

Until HSCRC Staff receives more information regarding these aforementioned issues, we are not in a position to complete our normal CON review on the financial feasibility of the project. The project assumes and is dependent upon a revenue increase of $21.5 million. Nothing has been provided to date that justifies this revenue increase.

Monitoring Maryland Performance

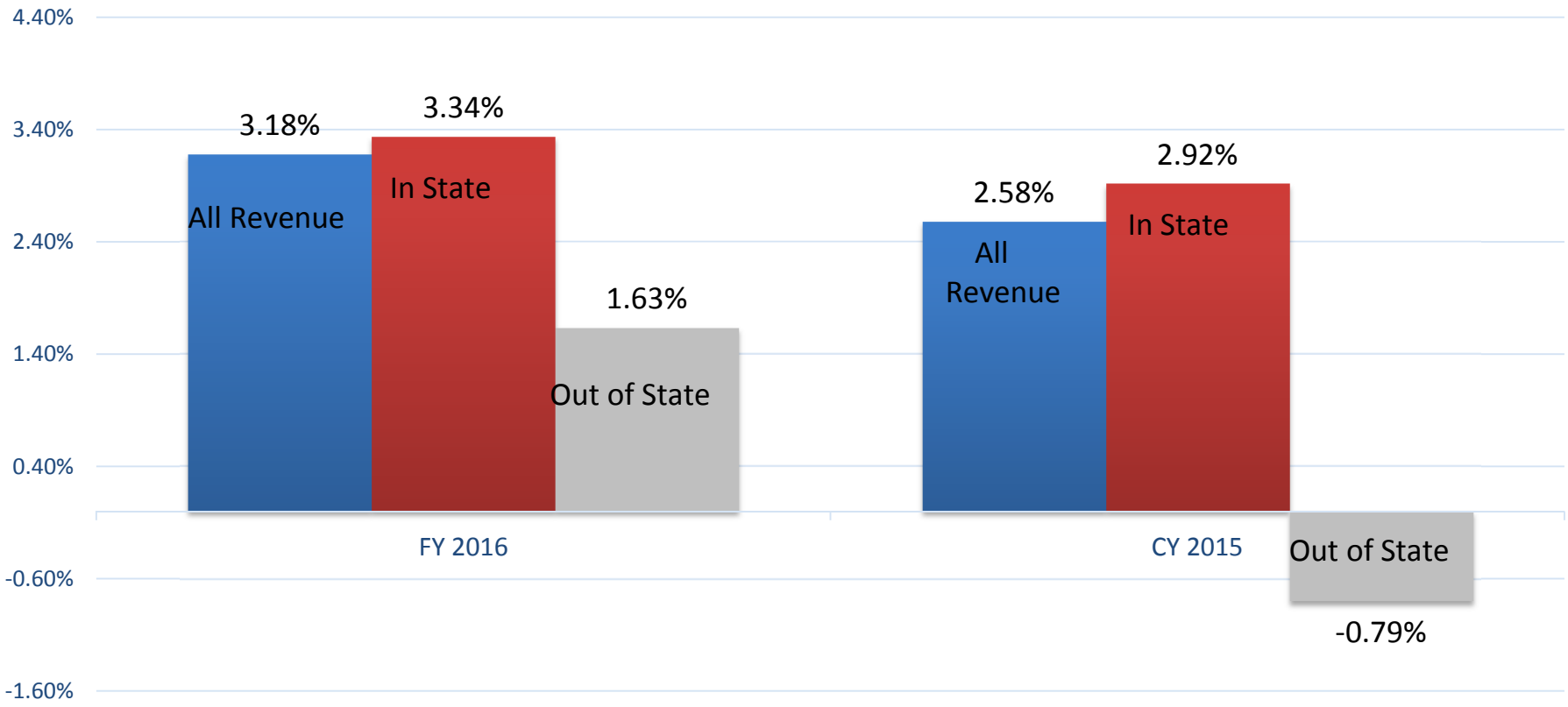
Financial Data

Year to Date thru 2015

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

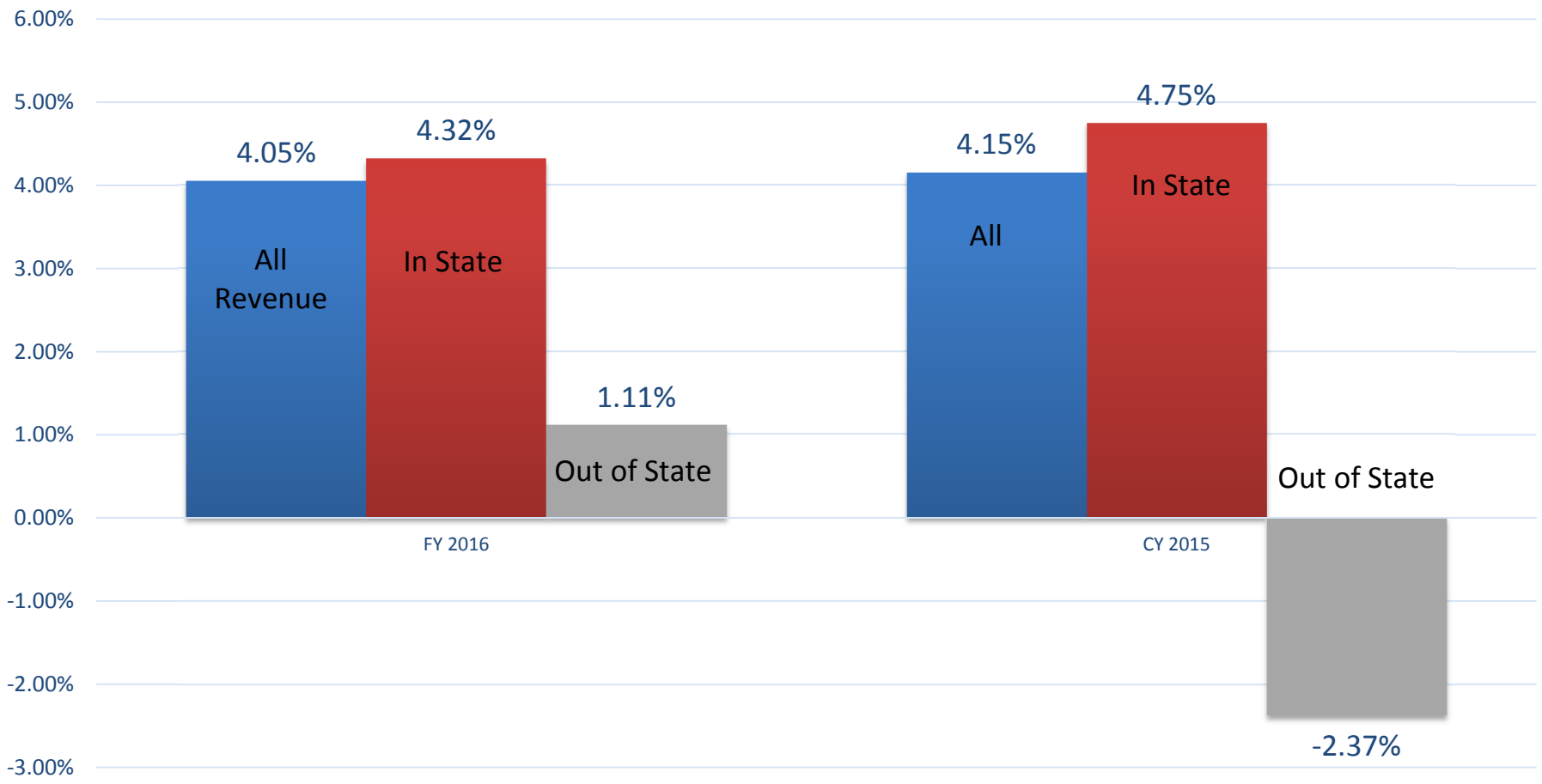
Year to Date (thru September 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

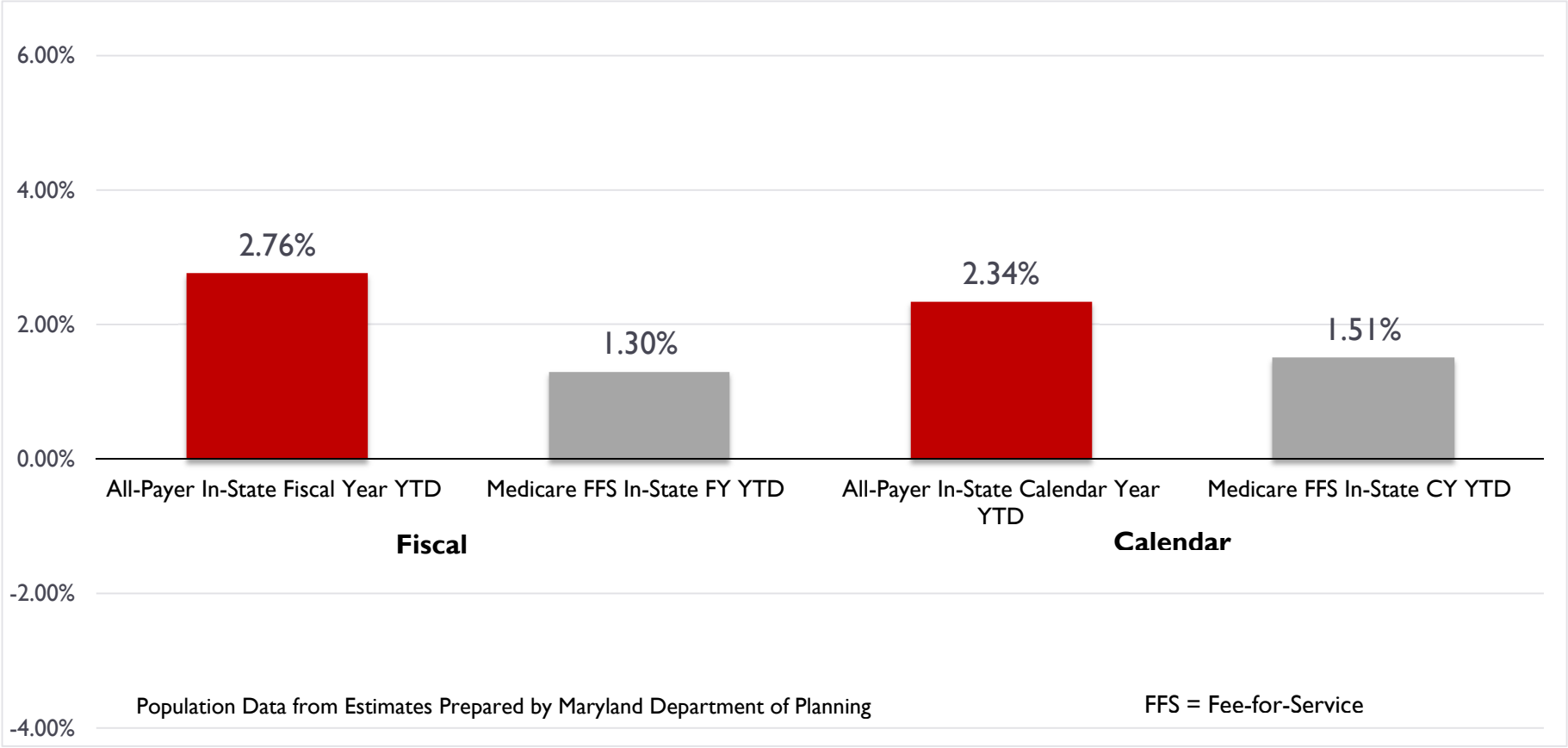
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru September 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2015

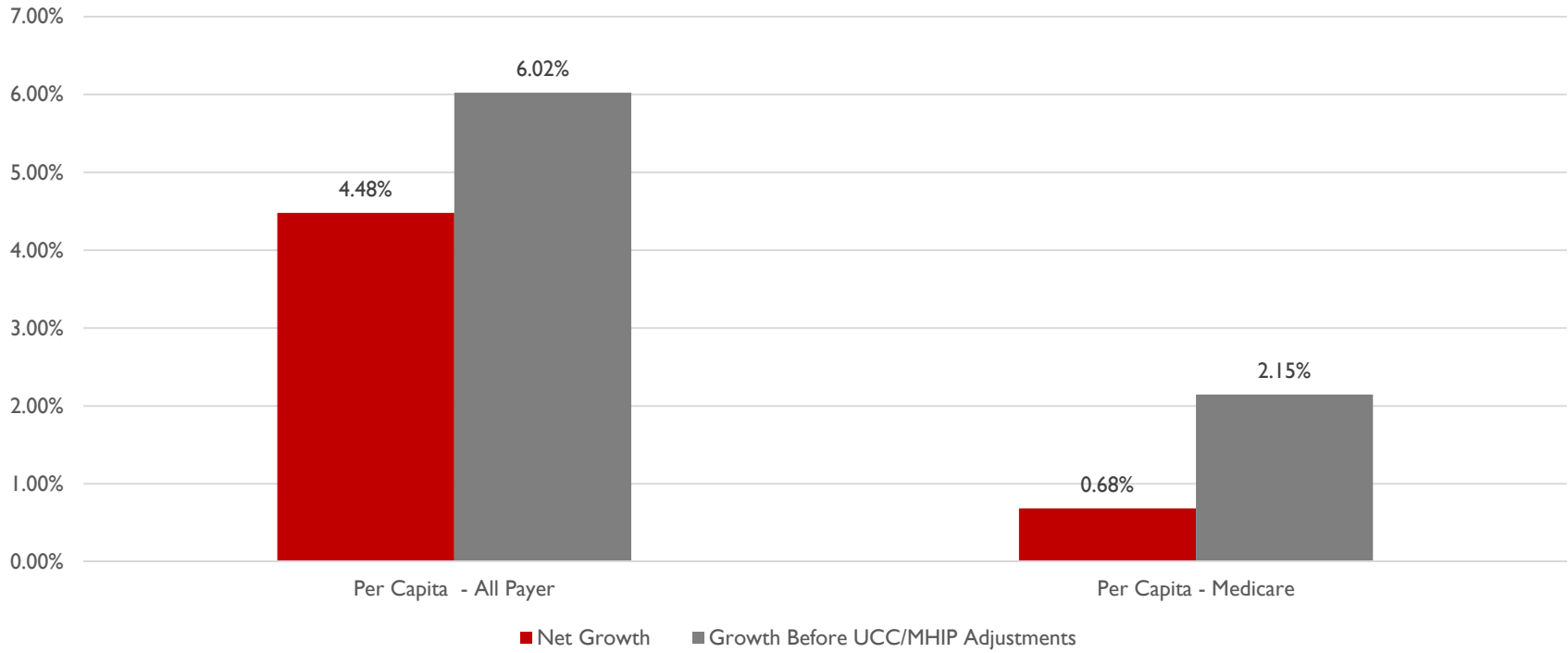


- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

HSCRC
Health Services Cost Review Commission

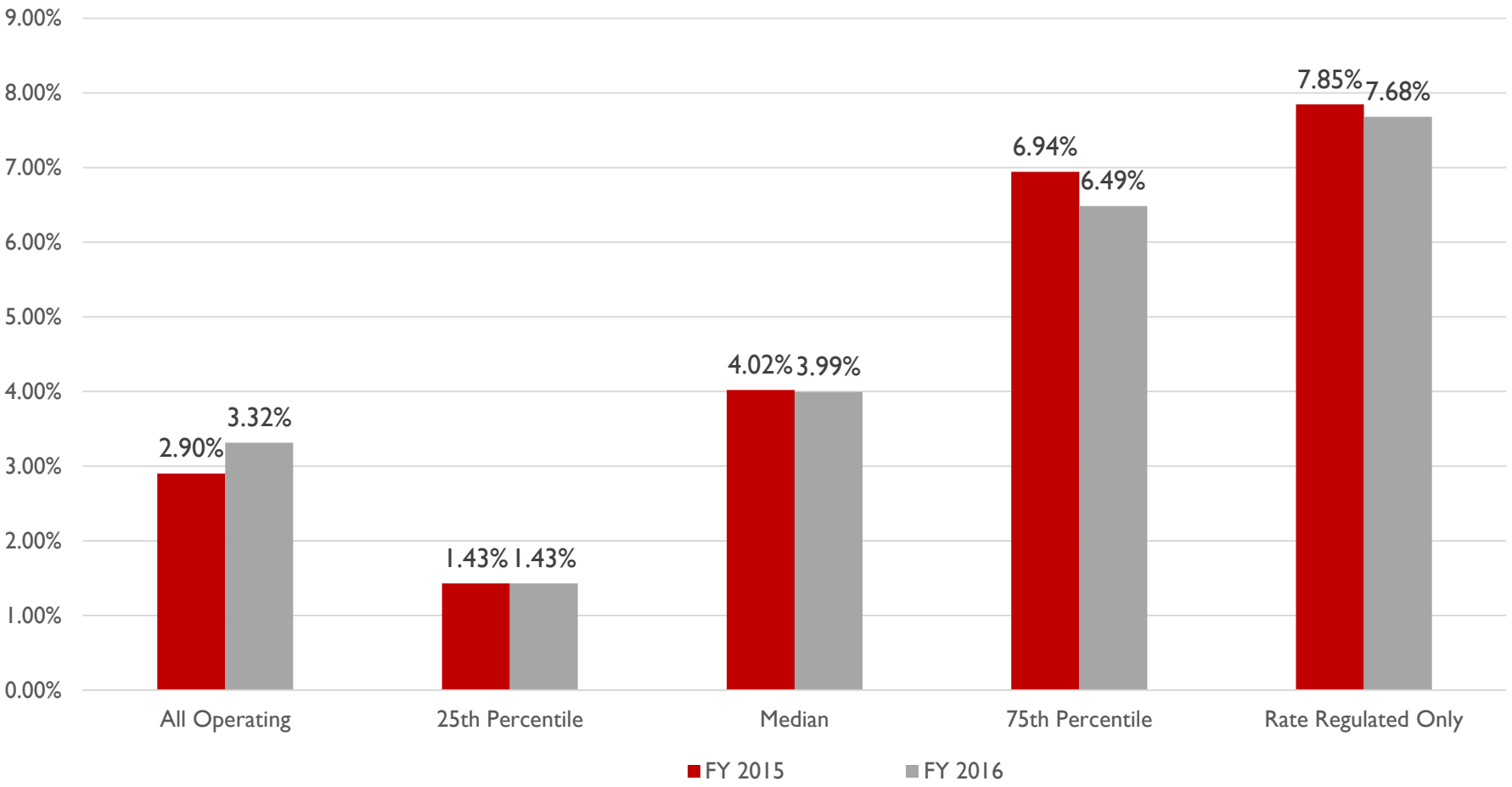
Per Capita Growth – Actual and Underlying Growth

CY 2015 Year to Date Compared to Same Period in Base Year (2013)



- Two year per capita growth rate is well below maximum allowable growth rate of 7.29% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 15 & FY 16 revenue decreases that were budget neutral for hospitals. 1.09% decrease from MHIP assessment and hospital bad debts in FY 15. Additional 1.41% adjustment in FY 16 due to further reductions to hospital bad debts and elimination of MHIP assessment.

Operating Profits: Fiscal 2016 Year to Date (July-September) Compared to Same Period in FY 2015

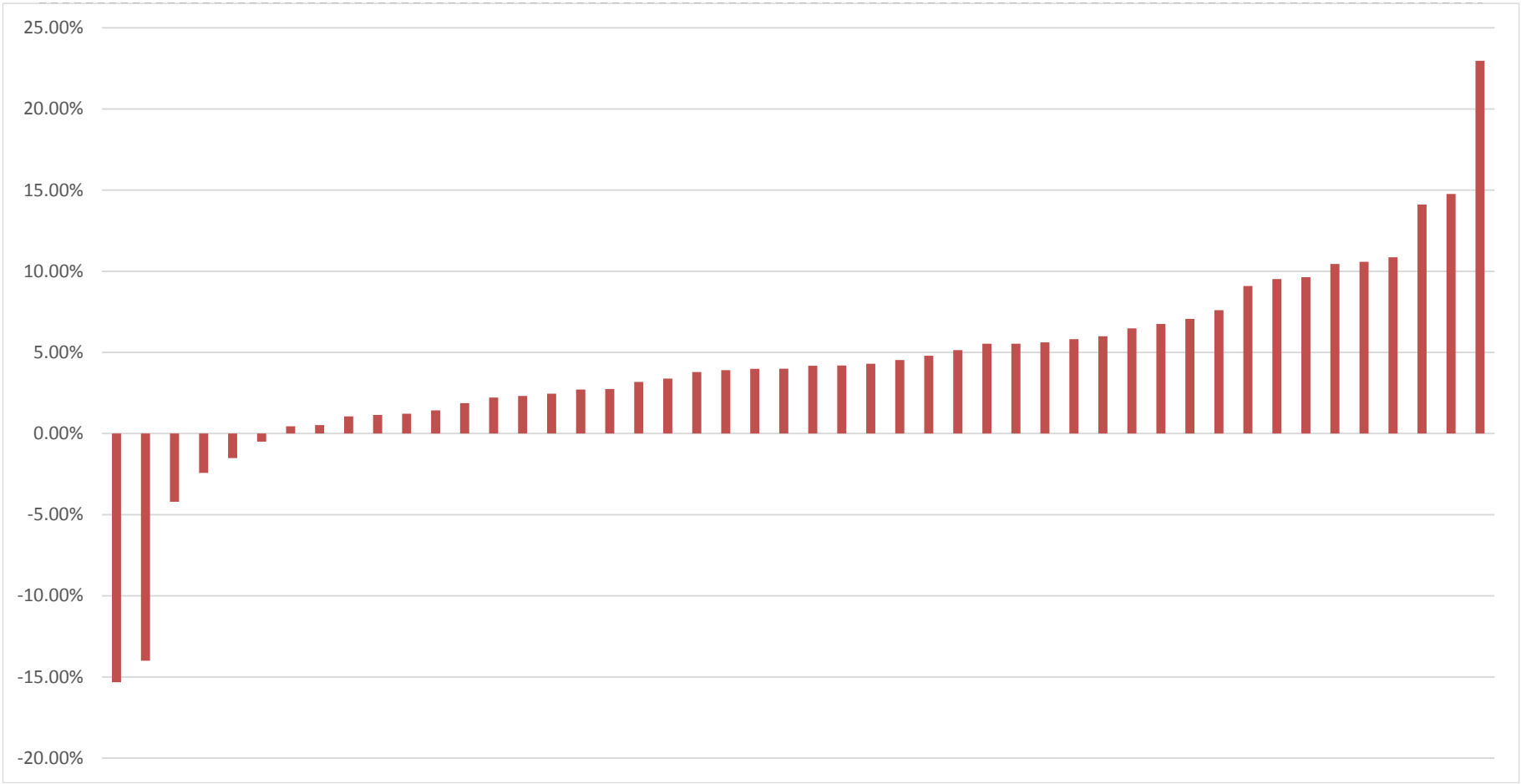


- Year to date FY 2016 unaudited hospital operating profits shows little change compared to the same period in FY 2015.

HSCRC
Health Services Cost Review Commission

Operating Profits by Hospital

Fiscal Year to Date (July – September)



HSCRC
Health Services Cost Review Commission

Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

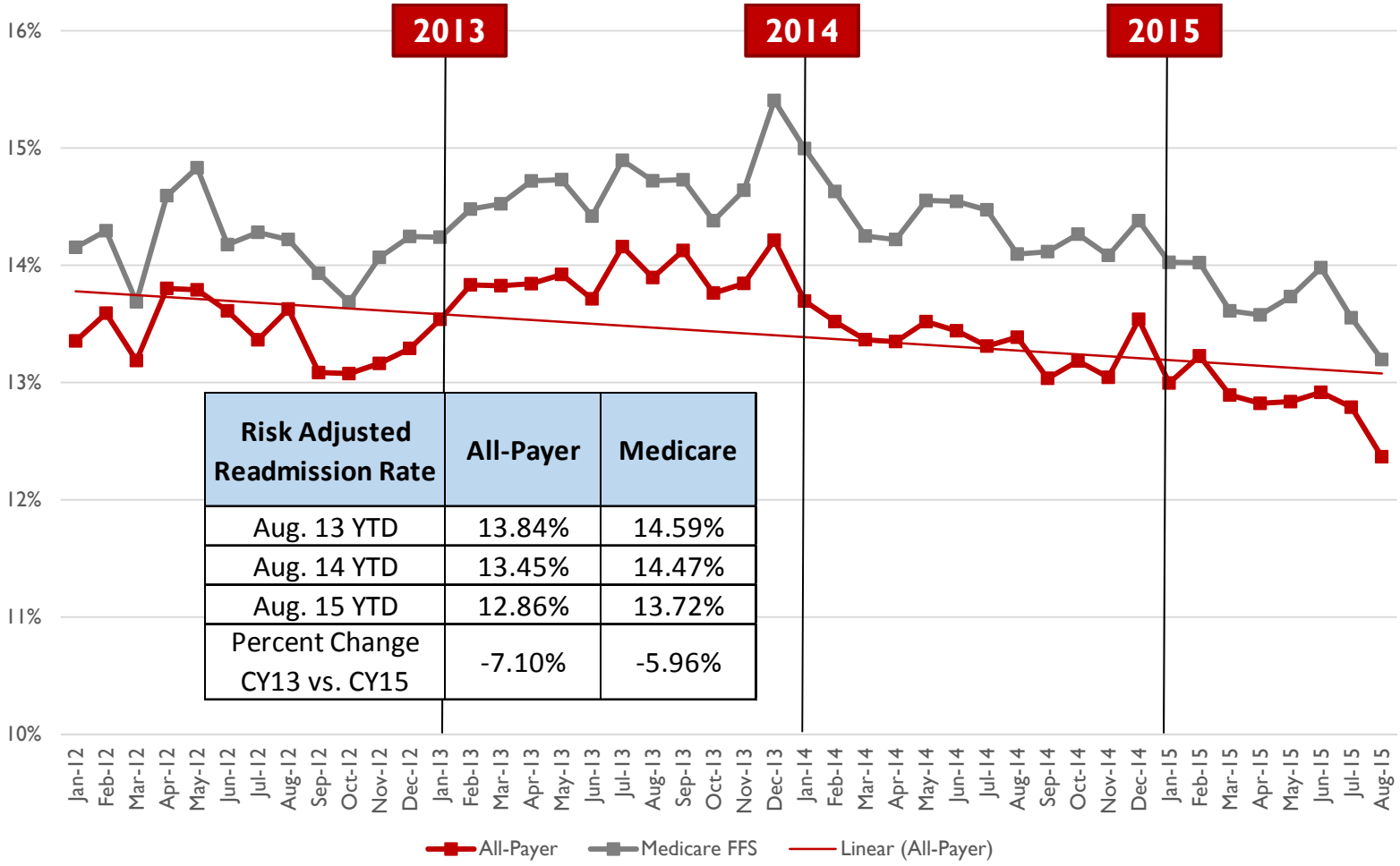
Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .56% for FY 16 and .56% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Quality Data

November 2015 Commission Meeting Update

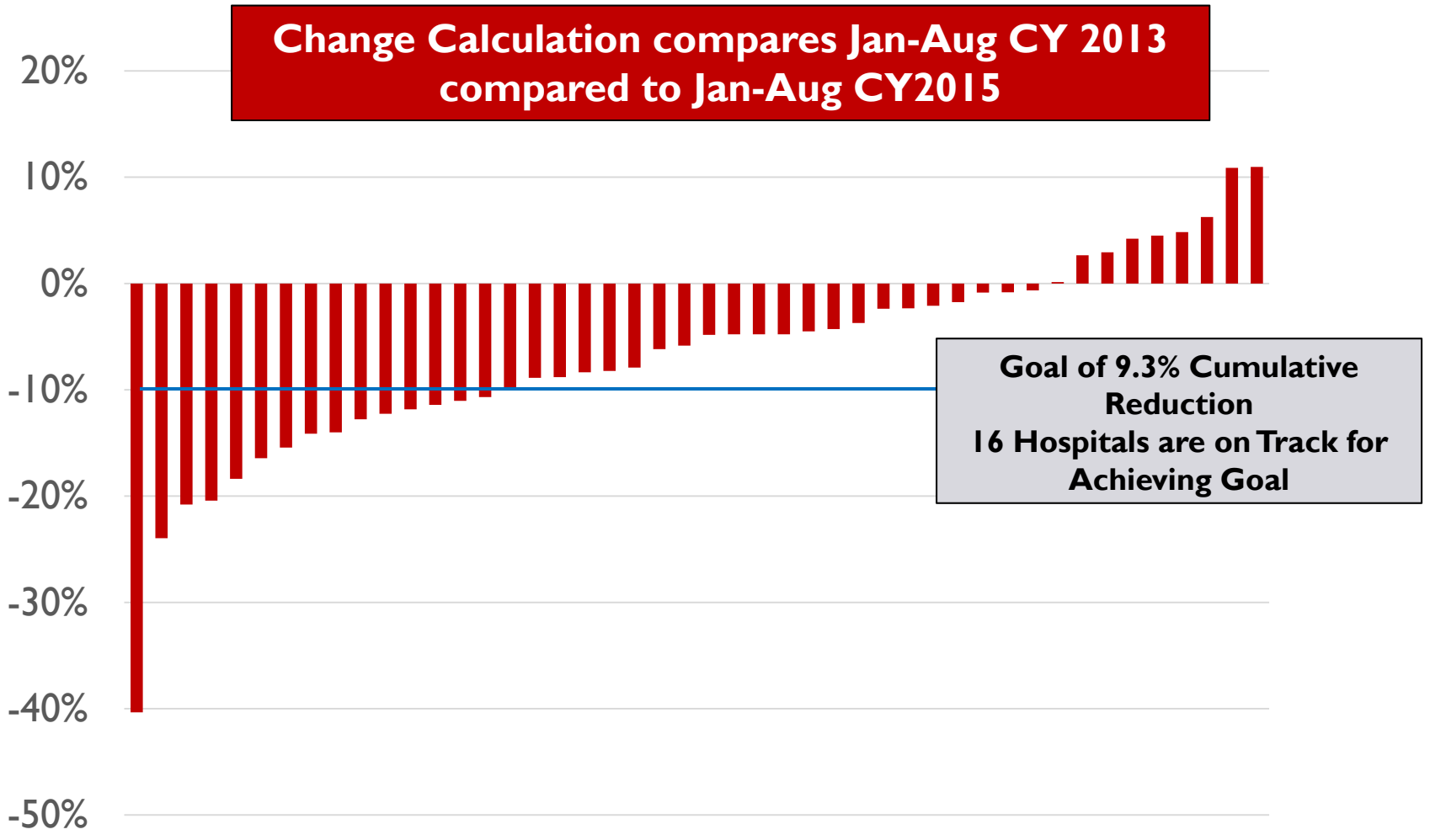
Monthly Risk-Adjusted Readmission Rates



Risk Adjusted Readmission Rate	All-Payer	Medicare
Aug. 13 YTD	13.84%	14.59%
Aug. 14 YTD	13.45%	14.47%
Aug. 15 YTD	12.86%	13.72%
Percent Change CY13 vs. CY15	-7.10%	-5.96%

Note: Based on final data for January 2012 – June 2015, and preliminary data through September 2015.

Change in All-Payer Risk-Adjusted Readmission Rates by Hospital



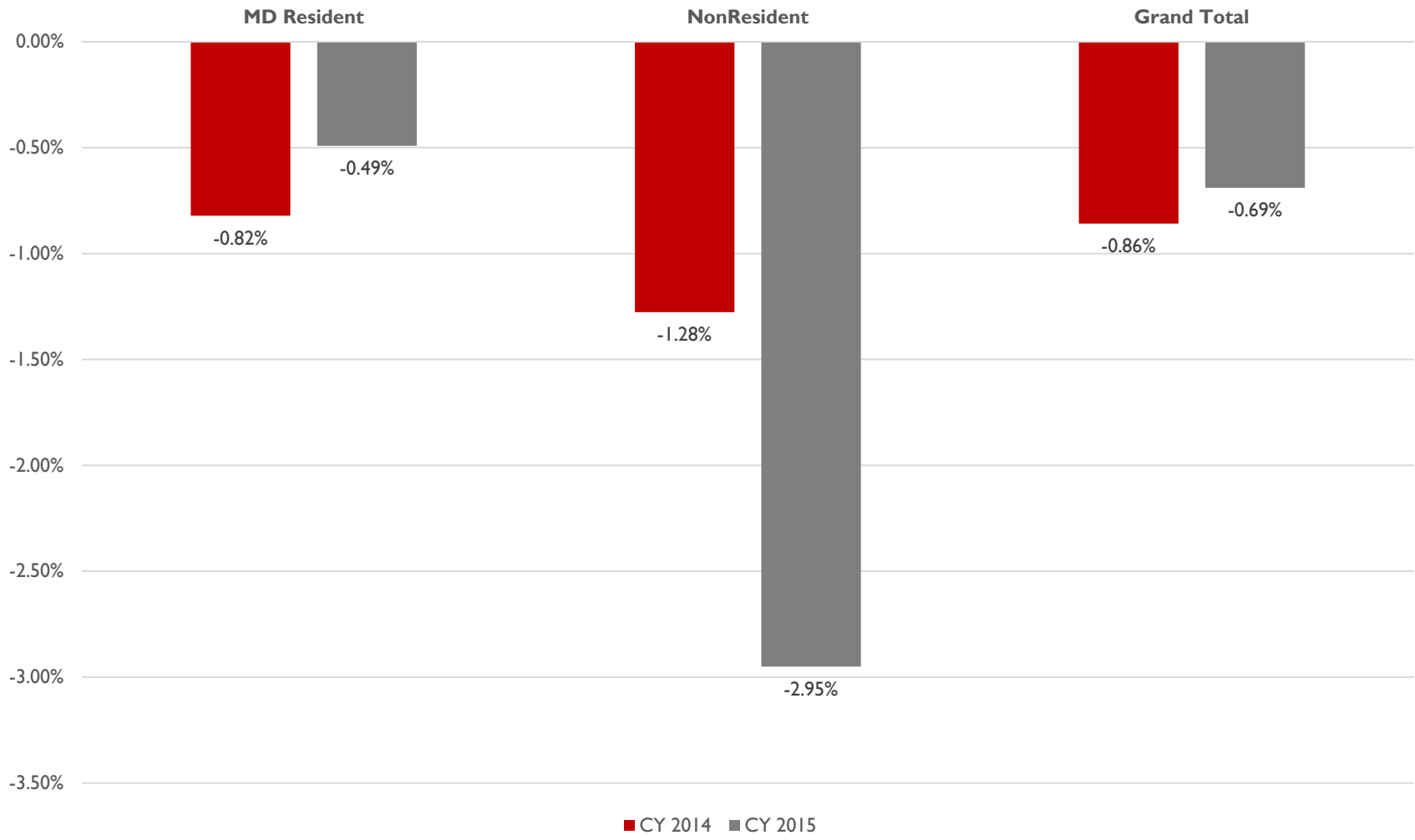
Note: Based on final data for January 2012 – June 2015, and preliminary data through September 2015.

HSCRC
Health Services Cost Review Commission

Monitoring Maryland Performance
Preliminary Utilization Trends

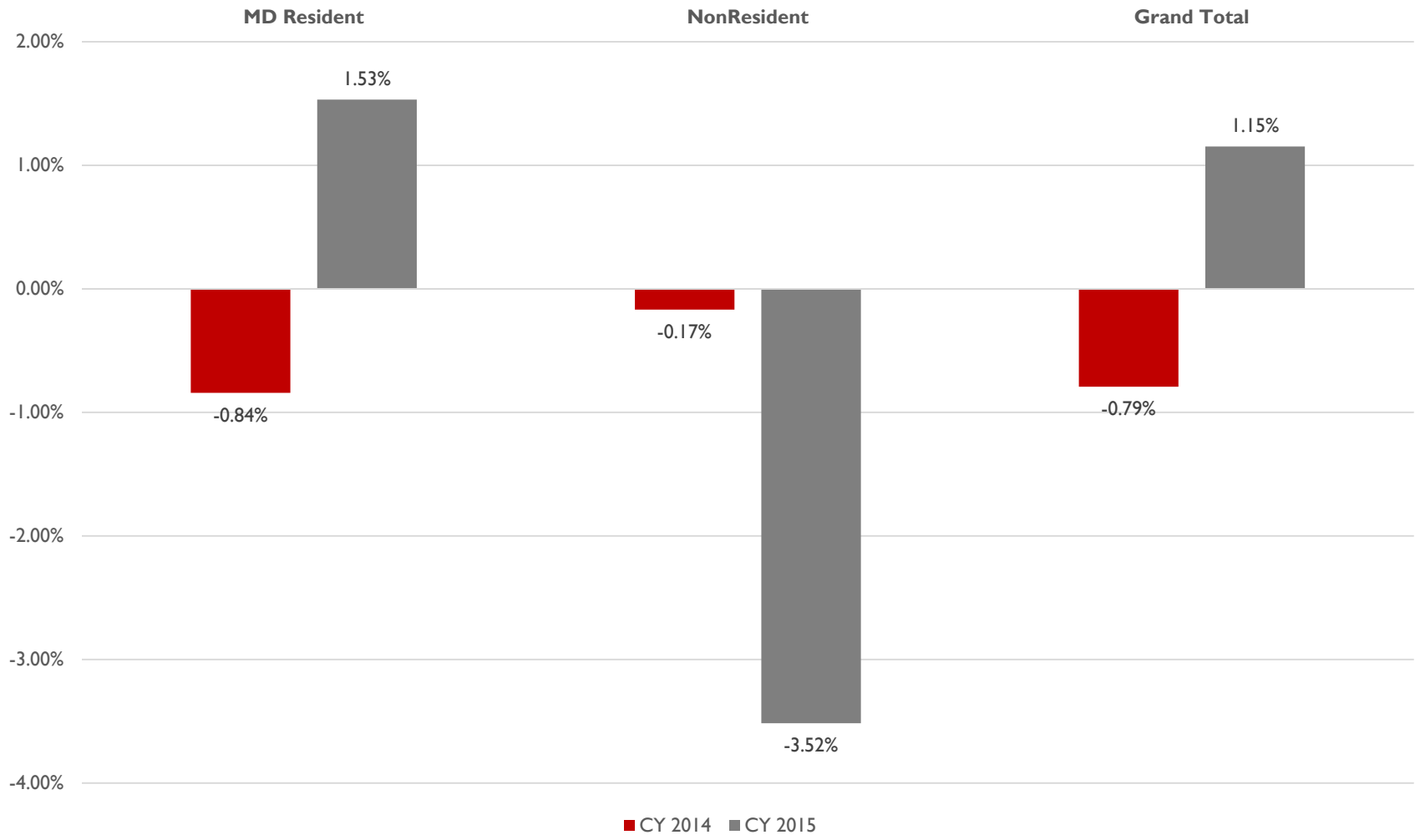
Year to Date thru August 2015

All Payer ECMAD GROWTH - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year



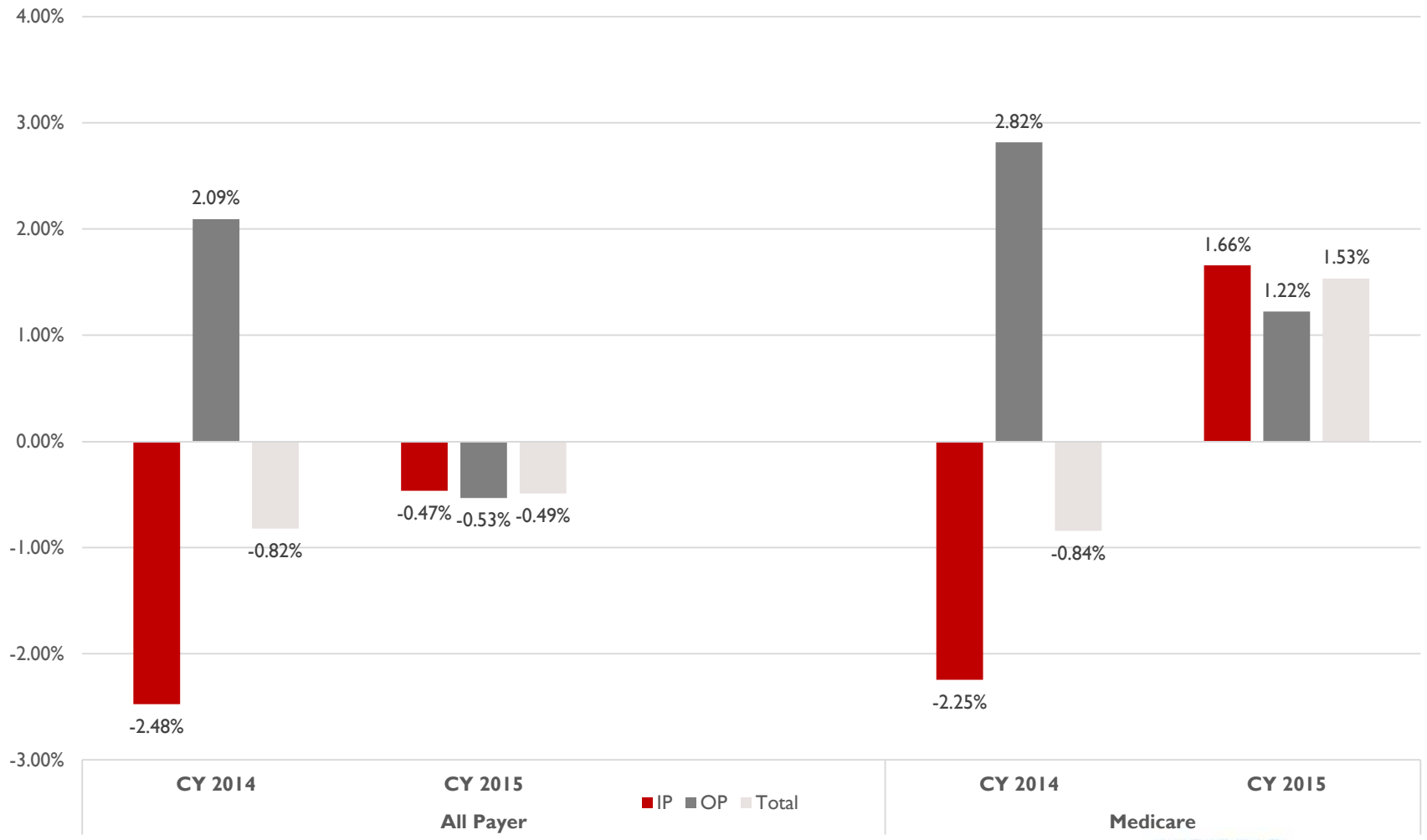
HSCRC
Health Services Cost Review Commission

Medicare ECMAD GROWTH - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year



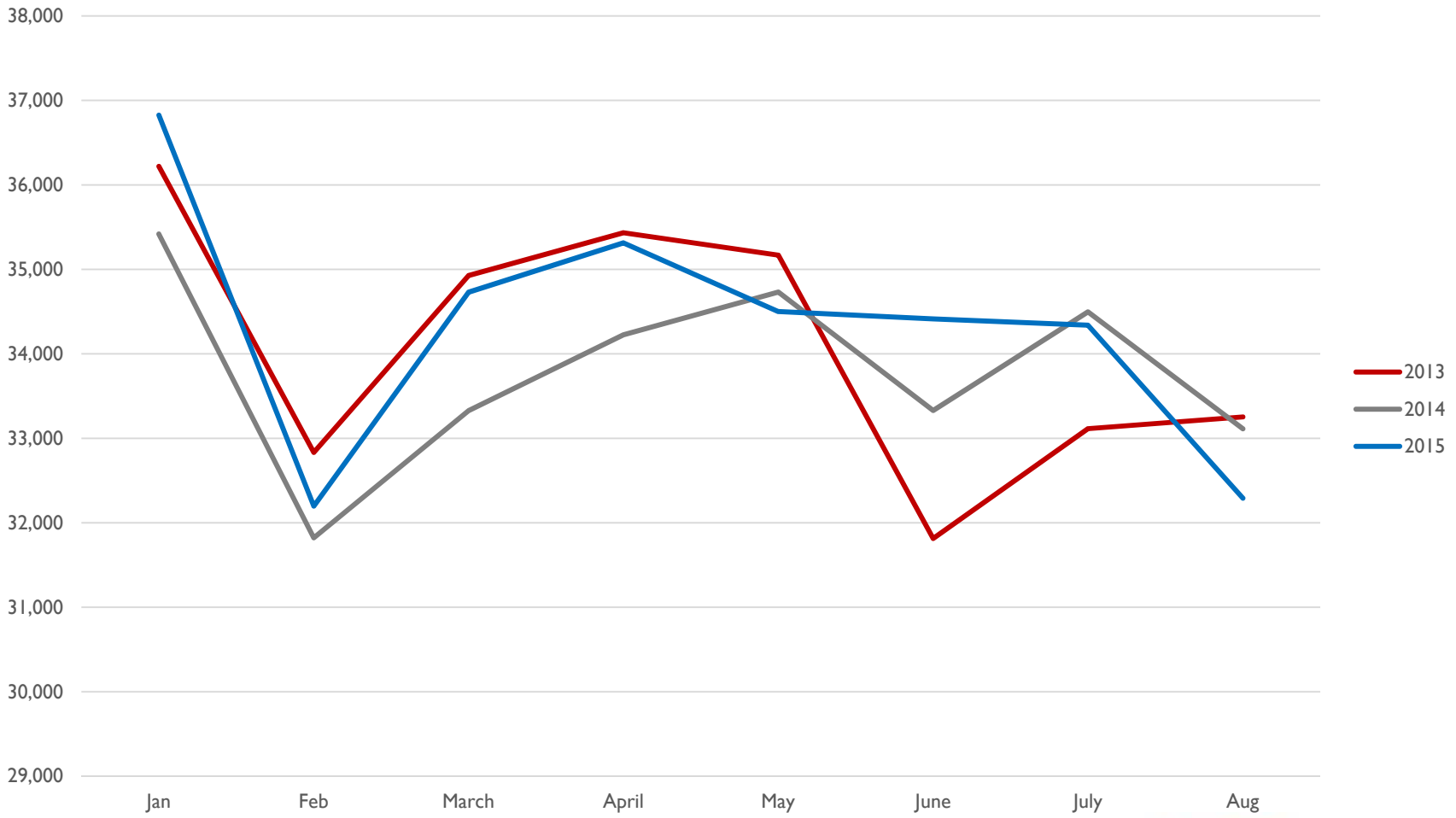
HSCRC
Health Services Cost Review Commission

MD Resident ECMAD GROWTH by Location of Service - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year



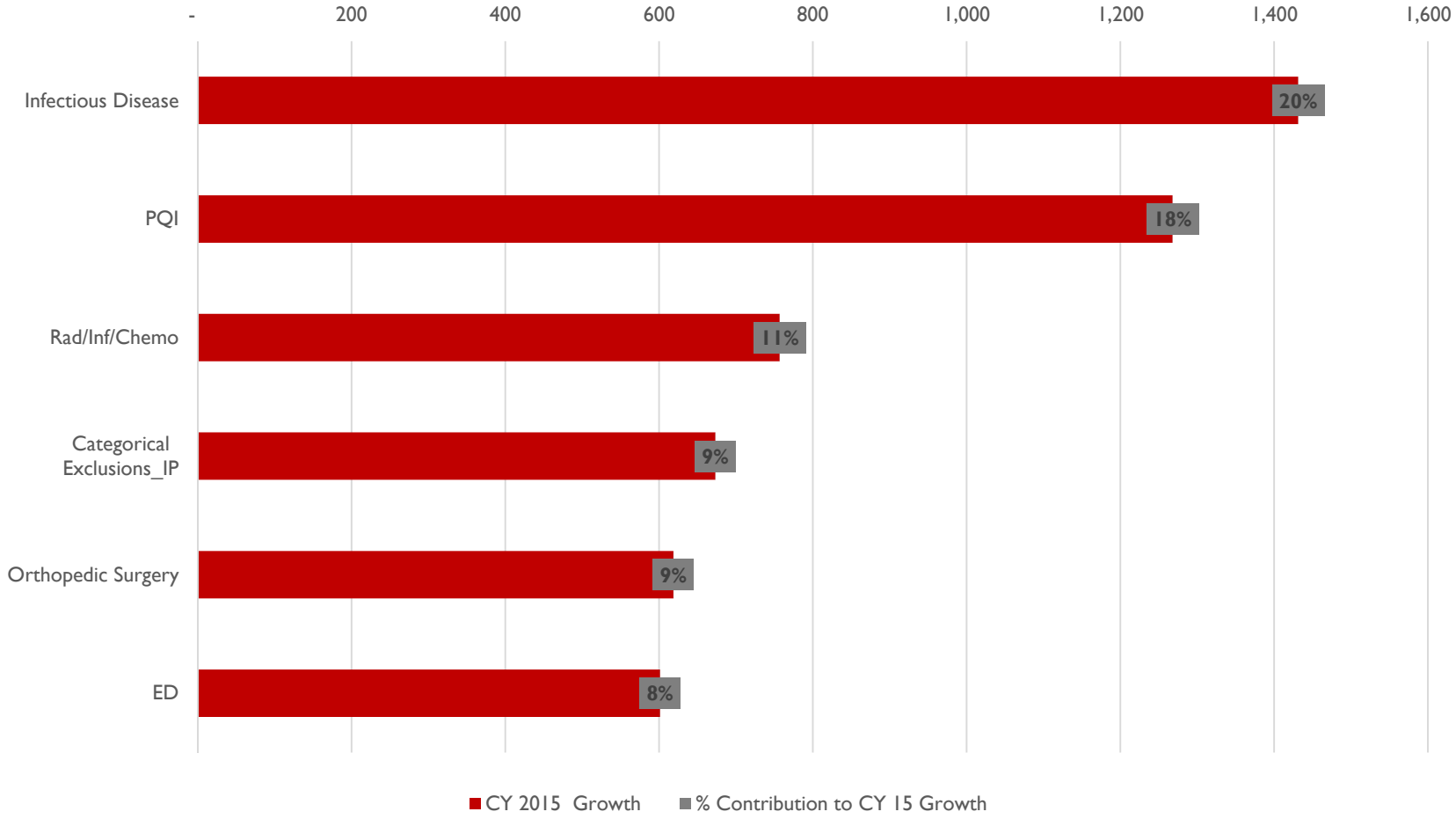
HSCRC
Health Services Cost Review Commission

Medicare MD Resident ECMAD GROWTH by Month



HSCRC
Health Services Cost Review Commission

Medicare MD Resident ECMAD Growth by Service Line
Calendar Year to Date ECMAD Growth (thru August)



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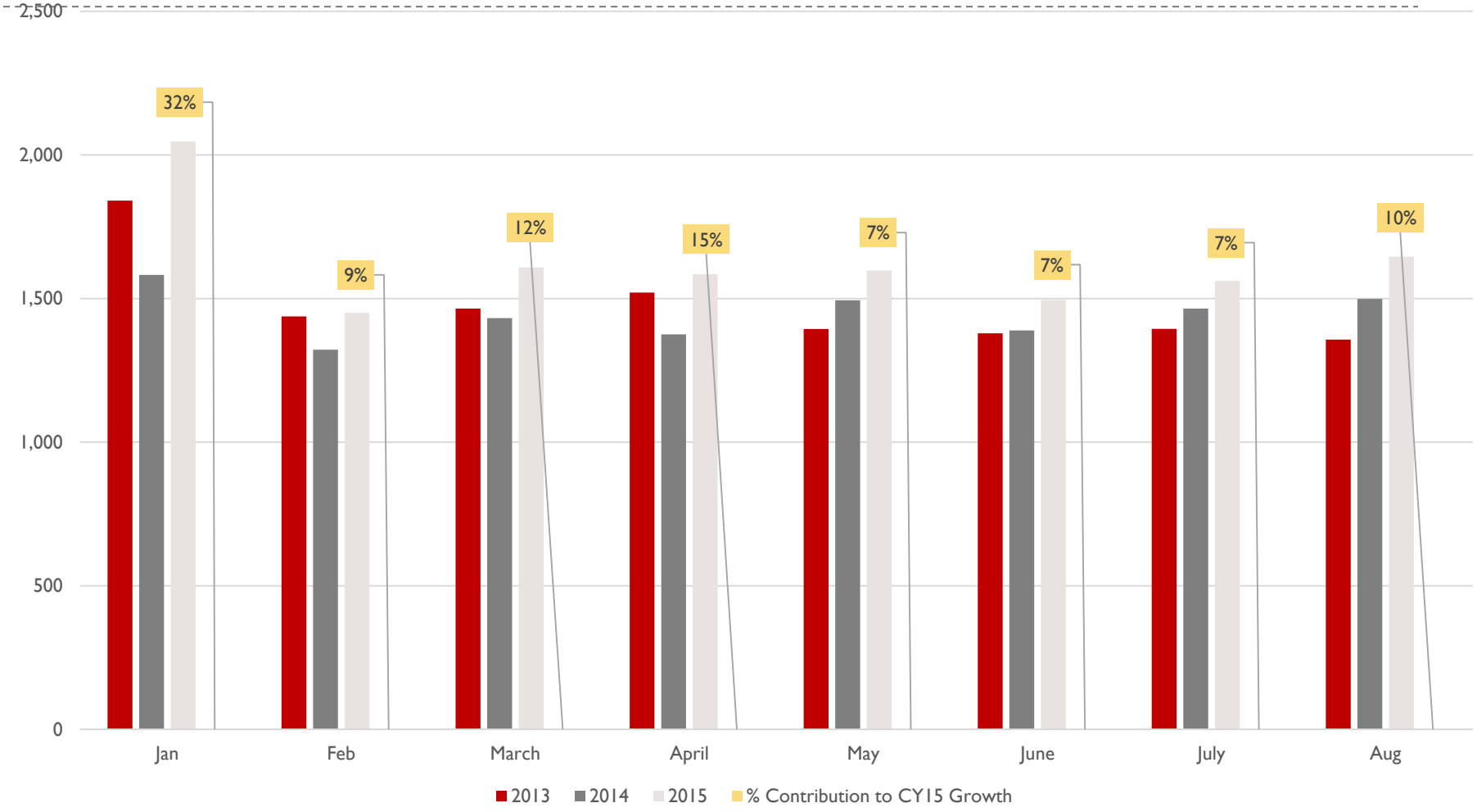
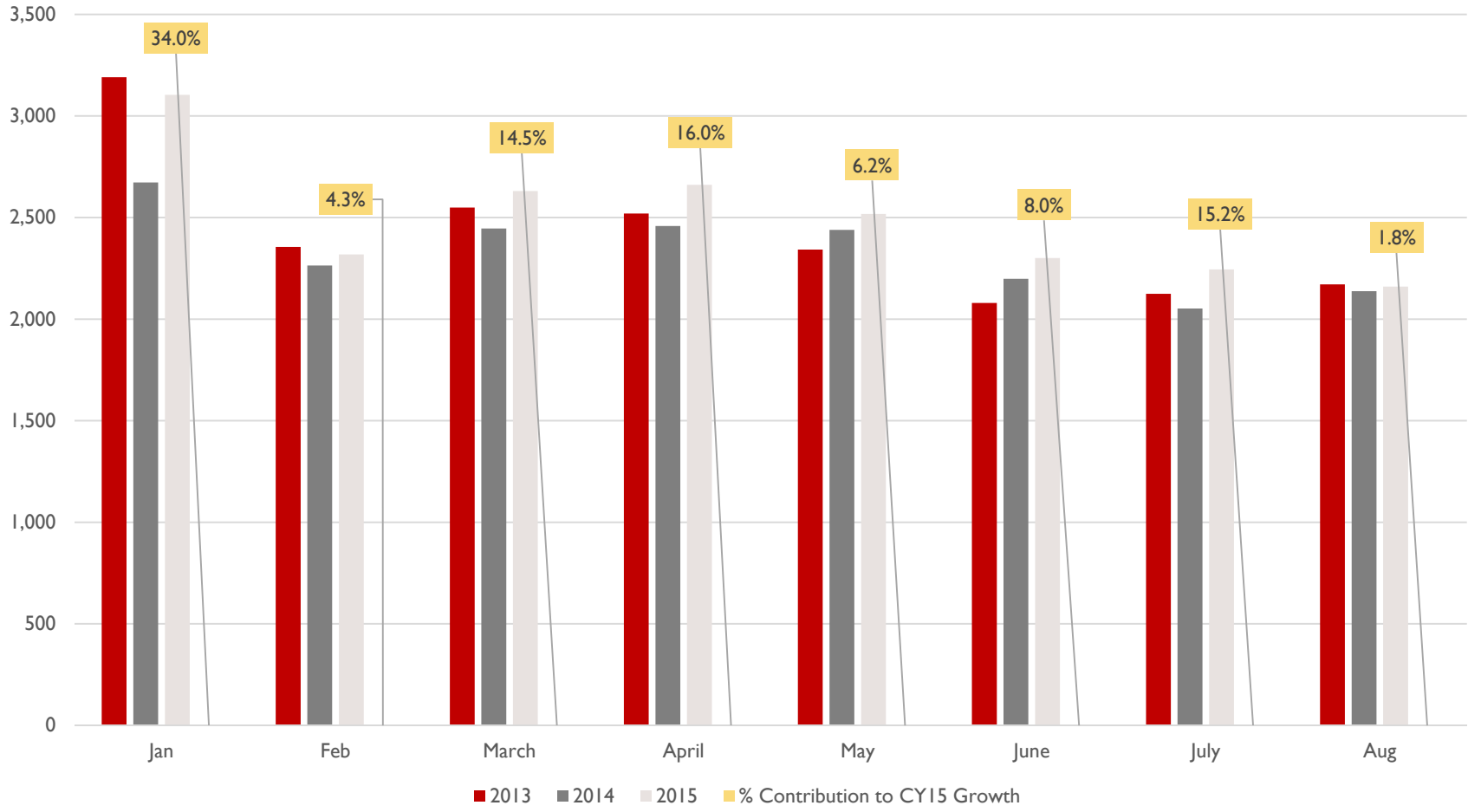
Health Services Cost Review Commission

Medicare MD Resident Infectious Disease Service Line ECMAD GROWTH by Month



HSCRC
Health Services Cost Review Commission

Medicare MD Resident PQI Service Line ECMAD GROWTH by Month



HSCRC
Health Services Cost Review Commission

Utilization Analytics – Data Notes

- Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  - 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
- Observation stays with more than 23 hour are included in the inpatient counts
  - IP=IP + Observation cases >23 hrs.
  - OP=OP - Observation cases >23 hrs.
- Preliminary data, not yet reconciled with financial data
- Careful review of outpatient service line trends is needed
- Tableau Visualization Tools

Service Line Definitions

- Inpatient service lines:
  - APR DRG to service line mapping
  - Readmissions and PQIs are top level service lines (include different service lines)
- Outpatient service lines:
  - Highest EAPG to service line mapping
  - Hierarchical classifications (ED, major surgery etc)
- Market Shift technical documentation

Cases Closed

The closed cases from last month are listed in the agenda

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2015**
ST. JOSEPH MEDICAL CENTER	*	**FOLIO: 2114**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2304N**

Staff Recommendation

November 18, 2015

Introduction

On July 17, 2015 University of Maryland St. Joseph Medical Center (the "Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a new rate for Definitive Observation (DEF) and Coronary Care (CCU) services. The Hospital requests that the DEF and CCU rates be set at the lower of a rate based on its projected costs to provide DEF and CCU services or the statewide median and be effective November 1, 2015.

Staff Evaluation

To determine if the Hospital's DEF and CCU rates should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for DEF and CCU for FY 2015. Based on information received from the Hospital, the DEF and CCU rates would be $1,349.80 per patient day and $2,965.00 per patient day respectively. The statewide median for DEF and CCU services are $1,120.45 per patient day and $2,038.36 per patient day respectively.

This rate request is revenue neutral and will not result in any additional revenue to the Hospital, since it involves carving out DEF and CCU services from the current approved revenue for Med. /Surg. Acute (MSG) and Med/Surg. Intensive Care (MIS) services respectively. The Hospital currently charges DEF as a rollup to its MSG rate and charges CCU as a rollup to its MIS rate. The Hospital wishes to carve these services out to provide a more equitable charging of its patients. The new proposed rates are as follows:

	Current Rate	New Rate	Budgeted Volume	Approved Revenue
Med./Surg. Acute	$1,147.14	$1,162.16	30,671	$35,168,925
Definitive Observation	N/A	$1,120.45	17,265	$19,682,434
Med./Surg. Intensive Care	$2,433.09	$2,507.77	5,243	$13,249,849
Coronary Care	N/A	$2,038.36	992	$1,882,296

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That a MSG rate of $1,162.16 per patient day be approved effective November 1, 2015;
2. That a DEF rate of $1,120.45 per patient day be approved effective November 1, 2015;
3. That a MIS rate of $2,507.77 per patient day be approved effective November 1, 2015;
4. That a CCU rate of $2,038.36 per patient day be approved effective November 1,2015;
5. That the MSG, DEF, MIS and CCU rates not be rate realigned until a full year's cost experience data have been reported to the Commission; and
6. That no change be made to the Hospital's Global Budget Revenue.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
SAINT AGNES HEALTH	*	**COMMISSION**	
WESTERN MARYLAND HEALTH SYSTEM	*	**DOCKET:**	**2015**
MERITUS HEALTH	*	**FOLIO:**	**2117**
HOLY CROSS HEALTH	*	**PROCEEDING:**	**2307A**

Final Recommendation

November 18, 2015

This is a final recommendation and ready for Commission action.

I. Introduction

On August 21, 2015, Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health ("the Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2270A for the period January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for one year beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. MPC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MPC is a major participant in the Medicaid Health Choice program, and provides services to 18.2% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2014.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2270A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2014 was favorable; however, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. MPC is projecting to resume favorable performance in CY 2016.

IV. Recommendation

With the exception of CY 2013, MPC has generally maintained favorable performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2015 and the MCO's expected financial status into CY 2016. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015

experience, preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipuhtes that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2015**
	*	**FOLIO:**	**2118**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2308A**

Final Recommendation

November 18, 2015

This is a final recommendation and ready for Commission action.

I. Introduction

On September 14, 2015, Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Suburban Hospital, and Howard County General Hospital ("the Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2269A for the period from January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the initially revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services to 23.6% of the State's MCO population, up from 22.8% in CY 2014.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2269A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. The statements provided by Priority Partners to staff represent both a "stand-alone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under the one entity of the MCO.

In recent years, the consolidated financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY2014 was positive. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. Priority Partners is projecting to resume favorable performance in CY 2016.

IV. Recommendation

Priority Partners has continued to achieve favorable consolidated financial performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2015, and the MCOs expected financial status in to CY 2016. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience, and preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.**
3) **Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals,**

and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2015**
	*	**FOLIO:**	**2120**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2310A**

Final Recommendation

November 18, 2015

This is a final recommendation and ready for Commission action.

I. Introduction

On September 21, 2015, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital ("the Hospitals"). MedStar Health seeks renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2257A for the period from January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for one year beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, while MFC receives a State-determined capitation payment. MFC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MFC provides services to 6.2% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2014.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2257A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY 2014 was positive. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. MFC is projecting to resume favorable performance in CY 2016.

IV. Recommendation

MFC has continued to achieve favorable financial performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past performance, staff believes that the proposed renewal arrangement for MFC is acceptable under Commission policy.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.

(2) Since sustained losses may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance resumes in CY 2016. Staff recommends that MedStar Family Choice report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience

and preliminary CY 2016 financial performa nce (adjusted for seasonality) of the MCO, as well as projections for CY 2017.

(3) Consistent with its policy paper outlining a structure for review and evaluatio n of applications for alternative methods of rate determination, the staff recommends that this appro val be co ntingent u pon the continued adherence to the stan dard Memorandum of Understanding with the Ho spitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annua l reporting, the confidentialit y of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract The MOU also stipuhtes that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2015**
	*	**FOLIO:**	**2121**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2311A**

Amended

Final Recommendation

November 18, 2015

I. Introduction

On September 23, 2015, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the "Hospitals"). MedStar Health seeks approval for MedStar Family Choice ("MFC") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Hospitals are requesting an approval for one year beginning January 1, 2016.

II. Background

MFC has been operating a CMS-approved Medicare Advantage Plan under the plan name of MedStar Medicare Choice for the last three years in the District of Columbia. Last year CMS granted MFC permission to expand under the same Medicare Advantage plan number to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Charles, Howard, Prince George's, St. Mary's counties and Baltimore City for CY 2015. The application requests continued approval for MFC to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. MFC will continue to pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

MFC supplied financial projections for its operations in Maryland for CY 2016.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2016, as well as MFC's experience and projections for CY 2015. The information reflected the anticipated negative

financial results associated with start-up of a Medicare Advantage Plan.

IV. Recommendation

Based on the financial projections and the fact that MFC has achieved favorable financial performance in its Maryland Medicaid's Health Choice Program, staff believes that the continued approval of the arrangement between CMS and MFC is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to continue to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016. The Hospitals must file a renewal application annually for continued participation. In addition, MFC must meet with HSCRC staff prior to August 31, 2016 to review its financial projections for CY 2017. In addition, UMHA must submit a copy of its quarterly and annual National Association of Insurance Commissioner's (NAIC's) reports within 30 days of submission to the NAIC.

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.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**
RATE APPLICATION OF	*	**SERVICES COST REVIEW**
UNIVERSITY OF MARYLAND MEDICAL	*	**COMMISSION**
SYSTEM CORPORATION		
	*	**DOCKET: 2015**
	*	**FOLIO: 2124**
*		**PROCEEDING: 2314A**

Final Recommendation

November 18, 2015

This is a final recommendation and ready for Commission action.

I. Introduction

On September 30, 2015, Riverside Health of Maryland, Inc. ("Riverside"), a Medicaid Managed Care Organization ("MCO"), on behalf of The University of Maryland Medical System Corporation ("the Hospitals"), filed an application for an Alternative Method of Rate Determination ("ARM") pursuant to COMAR 10.37.10.06. Riverside and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program. Riverside is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2281A for the period from January 1, 2015 through December 31, 2015. Under that arrangement, Riverside's hospital partners were LifeBridge Health, and Adventist Healthcare, Inc. In August of 2015, Riverside was purchased by University of Maryland Medical System Corporation. The MCO and Hospitals are requesting to implement this new contract for one year beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, Riverside, a MCO owned by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Riverside pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Riverside is a relatively small MCO providing services to 2.4% of the total number of MCO enrollees in the HealthChoice Program, which represents approximately the same market share as CY 2014.

Riverside supplied information on its most recent financial experience as well as its

preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2281A). Staff reviewed the operating financial performance under the contract. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In its second year of operation, Riverside reported positive financial performance for CY 2014. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. Riverside is projecting to resume favorable performance in CY 2016.

IV. Recommendation

Due to startup costs, Riverside's financial performance in its first year (CY 2013) was negative. Its financial performance in CY 2014 was favorable. However, all of the provider-based MCOs are expecting losses in CY 2015. Riverside is projecting a positive margin in CY 2016. Staff believes that the proposed renewal arrangement for Riverside is acceptable under Commission policy but will continue to monitor as the organization has recently changed its ownership arrangement.

Based on the information provided, staff believes that the proposed arrangement for Riverside is acceptable.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2015 and the MCO's expected financial status into CY 2016. Staff recommends that Riverside report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience, preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipuhtes that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
JOHNS HOPKINS HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2015**
	*****	**FOLIO:**	**2125**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2315A**

Amended

Final Recommendation

November 18, 2015

I. Introduction

On November 2, 2015, the Johns Hopkins Health System (JHHS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the "Hospitals"). JHHS seeks approval for Hopkins Health Advantage. Inc. ("HHA") to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. HHA is the JHHS entity that assumes the risk under this contract. JHHS is requesting an approval for one year beginning January 1, 2016.

II. Background

On September 1, 2015, CMS granted HHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Calvert, Carroll, Howard, Montgomery, Somerset, Washington, Wicomico, Worcester counties and Baltimore City. The application requests approval for the HHA to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. HHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

HHA supplied a copy of its contract with CMS and financial projections for its operations.

III. Staff Review

Staff reviewed the CMS contract and the financial information and projections for CYs 2016 and beyond.

IV. Recommendation

Based on the financial projections, staff believes that the proposed arrangement for HHA is acceptable under Commission policy.Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016. The Hospitals must file a renewal application annually for continued participation. In addition, HHA must meet with HSCRC staff prior to August 31, 2016 to review its financial projections for CY 2017. In addition, UMHA must submit a copy of its quarterly and annual National Association of Insurance Commissioner's (NAIC's) reports within 30 days of submission to the NAIC.

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.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2015**
SYSTEM	*	**FOLIO: 2126**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2316A**

Staff Recommendation

November 18, 2015

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on October 30, 2015 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective December 1, 2015.

II. OVE RVIEW OF APPLICATION

The parties to the contract include the System, DHMH, and CMS. The contract covers medical services provided to the PACE population. The assumptions for enrollment, utilization, and unit costs were developed on the basis of historical HEP experience for the PACE population as previously reviewed by an actuarial consultant. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF EVALUATION

Staff found that the experience under this arrangement for FY 2015 to be slightly unfavorable. The PACE Program Administrator explained that the relatively poor performance was attributable to several factors that have been addressed in this year's budget. The Program should produce a small profit in FY 2016. However, because the membership in the Program is restricted, one or two outlier hospital admissions could eliminate the surplus. Therefore, in taking a conservative approach, the Program is projecting a breakeven year in FY 2016.

III. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for one year beginning Decmber 1, 2015. The Hospital

will need to file a renewal application for review 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 formalizes the understanding between the Commission and the Hospital, and includes 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 also stipulates that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
UNIVERSITY OF MARYLAND	*****	**COMMISSION**	
MEDICAL SYSTEM	*****	**DOCKET:**	**2015**
	*****	**FOLIO:**	**2128**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2318A**

Amended

Final Recommendation

November 18, 2015

I. Introduction

On November 9, 2015, the University of Maryland Medical System (UMMS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the "Hospitals"). UMMS seeks approval for University of Maryland Health Advantage, Inc. ("UMHA") to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. UMHA is the UMMS entity that assumes the risk under this contract. UMHA is requesting an approval for one year beginning January 1, 2016.

II. Background

On September 1, 2015, CMS granted UMHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Caroline, Cecil, Carroll, Dorchester, Harford, Howard, Kent, Montgomery, Queen Anne's, Talbot counties and Baltimore City. The application requests approval for UMHA to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. UMHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

UMHA supplied a copy of its contract with CMS and financial projections for its operations.

III. Staff Review

Staff reviewed the CMS contract and the financial information and projections for CYs 2016 and beyond.

IV. Recommendation

Based on the financial projections, staff believes that the proposed arrangement for UMHA is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016. UMHA must meet with HSCRC staff prior to August 31, 2016 to review its financial projections for CY 2017. In addition, UMHA must submit a copy of its quarterly and annual National Association of Insurance Commissioner's (NAIC's) reports within 30 days of submission to the NAIC.

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.

Preliminary Staff Report for Commission Consideration Regarding Health Job Opportunity Program Proposal November 18, 2015

Overview Health Job Opportunity Program Proposal

At the Commission's September 9, 2015 public meeting, a panel of several hospital representatives and the Maryland Hospital Association proposed that the HSCRC provide up to $40 million through hospital rates to establish about 1,000 entry level health care jobs in areas of extreme poverty and unemployment. This staff report provides input on several options for Commission discussion, based on input from the Payment Models Workgroup, public comment, and staff policy analysis.

Background

The Health Job Opportunity Program Proposal ("Proposal") came about as a result of the unrest in Baltimore City and the strong belief that employment is an important element needed to change the current situation. Hospitals are among the largest employers in Baltimore City as well as in other areas of the State that have pockets of extreme poverty and unemployment. The Proposal seeks to create community-based jobs that can contribute to improved community health as well as hospital jobs that create employment opportunities in economically challenged areas.

All parties have acknowledged the importance of jobs in reducing economic disparities. However, there are critical differences in thinking about how creating job opportunities should be addressed and who should provide the funding for job creation.

This report focuses on synthesizing input and providing staff policy analysis for consideration by the Commission in determining how to approach this important proposal.

Analysis

Summary of Input Received--

Payment Models Work Group

The Payment Models Workgroup held a meeting to discuss this and other topics on October 5, 2015. Program description materials and a series of questions were sent out in advance of the meeting and posted to the website. Comments were also accepted from other individuals attending the meeting.

The work group members and other commenters expressed their appreciation for the leadership in bringing forward this proposal. All parties acknowledged the importance of jobs in reducing disparities.

Following is a general summary of work group comments, as presented in the Executive Director's report at the October 14, 2015 Commission meeting:

- Several commenters expressed the view that if the Commission were to take on a program of this nature, that it would be very important to define success. Success would need to be framed not only in creating jobs, but also in the context of the New All Payer Model and Triple Aim of improving care, improving health, and lowering costs.
    - A program that could not meet those requirements might be better implemented outside of the rate system.
    - Proposers of the Program indicated that evaluative criteria should be developed and that if the Program was not meeting those criteria, that it should be discontinued.
    - Because the jobs are entry level and for untrained workers, there was an indication that it might take some time to evaluate the impact on health and costs. Whether the jobs could be filled and the workers maintained could be determined much sooner.
- Several commenters felt that it would be important to focus on jobs outside of hospitals, such as Community Health Workers. The concern was expressed that the reduction of avoidable utilization in hospitals might reduce the need for some of the hospital jobs that were referred to in the Proposal.
    - One of the Academic Medical Centers felt that its utilization would not decrease with potentially avoidable utilization, but would backfill as out of state volumes increased or other referrals could be served.
    - One commenter expressed concern about the need for training of Community Health Workers, making sure they were prepared to be in the community working with frail and severely ill patients. (Note that there was a work group that recently produced a set of recommendations regarding Community Health Workers.) More design and structure would need to be in place.
- Several commenters felt that infrastructure adjustments already provided to hospitals, or the additional amount that is slated for award in January 2016, were already focused on similar activities and that this effort would be duplicative.
    - Proposers expressed that the infrastructure funds were already committed in their budgets for other purposes, and that a new source of funding is needed for rapid deployment of additional jobs.

    - Commenters indicated that a Return on Investment should be expected, similar to the recent infrastructure increases approved by the Commission.
- It was also suggested that other funding sources be considered for Program implementation.
    - The proposers indicated that this might slow the process down, or detract from the level of possible implementation and impact.
- Several commenters indicated that if the Proposal were to move forward, much more detailed design work needs to take place.
    - One suggestion was to ask the hospitals to organize an effort with other stakeholders and experts to further develop potential design criteria.
    - Another commenter indicated that the Commission staff might take this on and organize a work group to develop the program.
    - One commenter expressed concerns about accountability to payers, including the need for a return on investment.

Letters of Support and Public Comment

There were a number of letters of support received. Those include letters from public officials and other interested parties. These letters outline the need for jobs and support for the Proposal.

Letters were also received from DHMH-Medicaid and CareFirst. These letters express support for the need for jobs, but express concerns similar to those expressed in the payment work group regarding funding mechanisms and other considerations as outlined above.

All of these letters are attached to this report.

The Commission also heard from representatives of a community group, Baltimoreans United in Leadership Development (BUILD), at the October 14, 2015 Commission meeting. They stressed the importance of jobs in improving the situation in Baltimore. The representatives described existing programs that are making progress in employing individuals in economically deprived areas and the process they have used to ensure that the individuals employed through these programs are successful. The Staff and Commission were very appreciative of their presentation and advice regarding successful approaches that could be employed to make the Program work.

HSCRC Staff Commentary

The Commission and its staff are very concerned about health disparities and have focused extensive policy development around ensuring that resources are available for enhanced hospital care in areas of disparities. This includes financial policies such as disproportionate share adjustments that provide additional revenues to hospitals in areas of the State where there is a higher estimated level of poverty. These adjustments are derived from claims data

and indirect medical education allowances that provide revenues to hospitals, many of which are located in areas of the State with economic disparities. These policies have been applied in developing hospital rates for many decades. The HSCRC staff has also been attentive in developing value based performance measures to consider the impact of the social determinants of health. In fact, the HSCRC staff has been working on an Area Deprivation Index to enhance measurement of socioeconomic disparities and evaluating incorporating the index into its policies.

More needs to be done, however. In spite of significant amounts of additional funding provided to hospitals and a significantly higher amount of overall health care dollars being spent in areas of high socioeconomic disparities, serious disparities in health outcomes exist in Baltimore City as well as in other parts of the State. These disparities have been measured and documented in the State Health Improvement Plan. Hospitals have also recognized these disparities in their Community Health Needs Assessments.

The new All Payer Model recognized that a new approach is needed to address population health and disparities in outcomes. The Commission has approved numerous policies aimed at redirecting resources to this important objective including:

- Working with hospitals to move payment to global budgets so that when care and health are improved and utilization reduced, hospitals will be able to reinvest retained savings in interventions that are focused on improving health and outcomes. Hospitals have been accorded a great deal of flexibility in spending these resources.
- The Commission approved the funding of eight regional partnership grants focused on planning of patient-centered care coordination initiatives involving hospitals and community providers and partners. Out of $2.5 million of funding, 40% was provided to Baltimore City and Prince Georges County partnerships, counties where there are high levels of health disparities.
- By July 1, 2015, the Commission had placed more than $200 million of funding in rates earmarked for providing infrastructure and support for interventions to improve health and outcomes and reduce avoidable utilization. Hospitals have completed reports on historic expenditures, and strategic plans are due in December.
- In December of 2015, HSCRC will review grant applications for up to $40 million of care coordination initiatives that would be funded through hospital rates.

Others have devoted resources as well:

- The State of Maryland has also invested in programs focused on addressing health disparities in economically deprived areas such as the expansion of Medicaid and investments in Health Enterprise Zones.

- Hospitals, government agencies, and other grantors have also dedicated resources to individuals with disparities, including free clinics, transportation, some housing, as well as other interventions.
- Public health resources in Maryland are focused on similar needs.
- The significant Medicaid expansion which took place effective January 1, 2014, provided coverage for numerous individuals in areas of high deprivation, providing a source of health coverage that has improved the access to health care services, including preventive care.
- The federal government has provided grant awards, focused in part on workforce training. Several of the hospital awardees include hospitals located in Baltimore City.

With its new focus on chronic conditions and high needs patients, which are more prevalent in populations with health and economic disparities, HSCRC and hospitals will be directing funding toward reducing health disparities.

Relative to the Proposal, HSCRC staff has several concerns.

- Staff is concerned about including traditional jobs inside of hospitals in a grant program. These should be funded through hospital budgets. Furthermore, if the health care transformation is successful, hospital usage should decline and there is a concern that individuals in need of jobs might be employed in jobs that would be eliminated, thereby defeating the purpose of the Program.
- Staff supports expanding hospital resources deployed for positions that support the transitions anticipated in the All Payer Model-- care coordination, population health, health, information exchange, health information technology, alignment, and consumer engagement. However, staff is concerned about the funding sources and the potential for overlap with the additional resources that are being provided through rates as noted above. Furthermore, there are hospital community benefit dollars that could potentially be deployed in this effort. Grants are another potential source of funding.
- In order to implement programs such as those described above, significant amounts of training and coaching would be required. The programs require significant design and dedication of resources. HSCRC staff believes that considerable development needs to take place to plan, develop, and execute these programs successfully, similar to the planning and development that have gone into nursing education programs in the past.
- The HSCRC staff acknowledges the importance of jobs creation in areas of high economic deprivation, but staff is concerned about HSCRC's role in addressing this issue.

HSCRC Staff Options

Based on the commentary received to date, HSCRC staff offers several options, in no particular order of preference, for discussion with the Commission and for further public input.

Option 1—Earmark 25% (approximately $10 million) of the .25% pool for competitive transformation implementation grant funds for hospitals committing to hire workers from geographic areas of high socioeconomic deprivation to fill new care coordination, population health, health information exchange, alignment, consumer engagement, and related positions. Hospitals should provide matching funds to increase the resources that could be deployed. Under this option, staff would anticipate proposals for the $10 million from hospitals in March 2016, with implementation beginning by July 2016.

Option 2—Set aside $5 million of the .25% competitive transformation implementation grant funds to provide one time seed money for Program implementation once design is complete with expectation of implementation by July 2016. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, return on investment, hospital resources, and other grant, philanthropy, and foundation support. Under this option, staff would expect that program design would commence as soon as possible. The program design group would decide the best ways to deploy the $5 million in seed money including program development, training, coaching, funding of trainers, educators, coaches, etc. Hospitals would apply for the funds in March 2016, with anticipated implementation beginning by July 2016.

Option 3—Defer funding and have Proposers continue to develop Program design, implementation, and evaluation parameters by March 2016, together with AHECs and other job training resources, with a potential for future funding of some educational resources or seed funding in July 2016. Funding could potentially include program development, training, coaching, funding of trainers and coaches, etc. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, hospital resources such as return on investment, and other grant, philanthropy, and foundation support. HSCRC staff would expect that the resources provided would not be greater than the $5 million noted in Option 2 above.

Any of these options would require considerable development and structuring for success and accountability, and a fully developed evaluation process. If these or other options are pursued, resources will be needed to develop and administer the Program.

In summary, HSCRC staff understands the need for expansion of employment and for improvement in health outcomes and reductions in disparities for populations living in economically deprived areas of the State. The Commission has developed policies and

programs and provided funding that supports reducing health disparities under the All Payer Model. Staff has provided several options for discussion by the Commission regarding additional progress that might be made in developing employment opportunities, while addressing changes in hospital employment that are needed to successfully reach the goals of the new All Payer Model and the State Health Improvement Plan.

BARBARA A. MIKULSKI
MARYLAND

COMMITTEES:

APPROPRIATIONS

HEALTH, EDUCATION, LABOR, AND PENSIONS

United States Senate

WASHINGTON, DC 20510–2003

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BALTIMORE, MD 21231
(410) 962–4510
VOICE/TDD: (410) 962–4512

☐ 60 WEST STREET, SUITE 202
ANNAPOLIS, MD 21401–2448
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BALTIMORE: (410) 269–1650

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GREENBELT, MD 20770–1407
(301) 345–5517

☐ 32 WEST WASHINGTON STREET
ROOM 203
HAGERSTOWN, MD 21740–4804
(301) 797–2826

☐ THE PLAZA GALLERY BUILDING
212 MAIN STREET, SUITE 200
SALISBURY, MD 21801–2403
(410) 546–7711

September 1, 2015

Mr. John M. Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2254

Dear Mr. Colmers:

Your office will soon be receiving a proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. I am writing to express my strong support for the proposal and to urge you to give it every favorable consideration.

As outlined in the proposal, poverty is a contributing factor to poor health. A hospital employment program that targets impoverished communities not only improves the economic stability of the communities, this effort will also have a positive impact on the overall health of these communities. Because Maryland's All-Payer Model Agreement shifts hospital care towards a population health approach we believe this program is consistent with the Model Agreement.

I strongly support this collaborative and innovative approach toward population based health. Thank you for your consideration.

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:wbk

ELIJAH E. CUMMINGS
7TH DISTRICT, MARYLAND

RANKING MEMBER, COMMITTEE ON
OVERSIGHT AND GOVERNMENT REFORM

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JOINT ECONOMIC COMMITTEE

Congress of the United States
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Washington, DC 20515

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WASHINGTON, DC 20515–2007
(202) 225–4741
FAX: (202) 225–3178

DISTRICT OFFICES:

☒ 1010 PARK AVENUE
SUITE 105
BALTIMORE, MD 21201–5037
(410) 685–9199
FAX: (410) 685–9399

☐ 754 FREDERICK ROAD
CATONSVILLE, MD 21228–4504
(410) 719–8777
FAX: (410) 455–0110

☐ 8267 MAIN STREET
ROOM 102
ELLICOTT CITY, MD 21043–9903
(410) 465–8259
FAX: (410) 465–8740

www.house.gov/cummings

August 27, 2015

John M. Colmers
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Colmers:

I am writing to express support for the proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment.

As outlined in the proposal, poverty is a contributing factor to poor health. A hospital employment program that targets impoverished communities would not only improve economic stability, it would also have a positive impact on community health. Because Maryland's All-Payer Model Agreement shifts hospital care toward a population health approach, I believe this program is consistent with the Model Agreement.

I hope that you will give this proposal every reasonable consideration.

Sincerely,

Elijah E. Cummings
Member of Congress

DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

HOUSE COMMITTEE ON
SCIENCE, SPACE, AND TECHNOLOGY
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SUBCOMMITTEE ON WATER RESOURCES
AND ENVIRONMENT

Congress of the United States
House of Representatives
Washington, DC 20515–2004

September 2, 2015

John Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

I am writing to express support for the proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. Maryland may be one of the wealthiest states in the nation, but we continue to experience health disparities associated with low income. Further, empirical evidence has shown that the inability to obtain employment with growth opportunities consistently contributes to the cycle of poverty.

A hospital employment program that targets impoverished communities not only improves the economic stability of those communities, but also will have a positive impact on the overall physical health of these communities.

As you know, hospitals are some of the largest employers in many of Maryland's diverse communities, and I support a program that will hire thousands of Marylanders from low-income, high-unemployment zip codes. Because Maryland's All-Payer Model Agreement shifts hospital care towards a population health approach, I believe this program is consistent with the Model Agreement.

I strongly support this collaborative and innovative approach toward population based health care.

Sincerely,

Donna F. Edwards
Member of Congress

5001 SILVER HILL ROAD
SUITE 106
SUITLAND, MARYLAND 20746
TELEPHONE: (301) 516–7601
FAX: (301) 516–7608

2445 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–2004
TELEPHONE: (202) 225–8699
FAX: (202) 225–8714

877 BALTIMORE ANNAPOLIS BOULEVARD
RITCHIE COURT OFFICE BUILDING
UNIT 101
SEVERNA PARK, MD 21146
TELEPHONE: (410) 421–8061
FAX: (410) 421–8065

DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

HOUSE COMMITTEE ON
SCIENCE, SPACE, AND TECHNOLOGY
SUBCOMMITTEE ON THE ENVIRONMENT
SUBCOMMITTEE ON SPACE, RANKING MEMBER

HOUSE COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT,
PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT
SUBCOMMITTEE ON HIGHWAYS AND TRANSIT
SUBCOMMITTEE ON WATER RESOURCES
AND ENVIRONMENT

Congress of the United States
House of Representatives
Washington, DC 20515–2004

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

5001 SILVER HILL ROAD
SUITE 106
SUITLAND, MARYLAND 20746
TELEPHONE: (301) 516–7601
FAX: (301) 516–7608

2445 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–2004
TELEPHONE: (202) 225–8699
FAX: (202) 225–8714

877 BALTIMORE ANNAPOLIS BOULEVARD
RITCHIE COURT OFFICE BUILDING
UNIT 101
SEVERNA PARK, MD 21146
TELEPHONE: (410) 421–8061
FAX: (410) 421–8065

http://donnaedwards.house.gov

C.A. DUTCH RUPPERSBERGER
2ND DISTRICT, MARYLAND

REPLY TO:

☐ 2416 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-3061
FAX: (202) 225-3094

☐ 375 WEST PADONIA ROAD, SUITE 200
TIMONIUM, MD 21093
(410) 628-2701
FAX: (410) 628-2708

www.dutch.house.gov

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE
RANKING MEMBER

Congress of the United States
House of Representatives
Washington, DC 20515–2002

August 31, 2015

Mr. John Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Colmers:

I am writing to express my support for Johns Hopkins' proposal to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. This program was modeled on Maryland's Nursing Support Program, which alleviated a severe nursing shortage and saved the state over $100 million by reducing hospitals' dependence on contract nurses. Johns Hopkins' current proposal aims to create 1,000 jobs with a budget of less than $40 million per year using a portion of the "cushion" from Maryland's All-Payer Model Agreement.

The correlation between poverty and poor health is widely recognized. As some of the state's largest employers and community anchors, hospitals are uniquely positioned to address both of these issues. A hospital employment program that targets impoverished communities will improve not only the economic stability but also the overall health of these communities. As hospitals shift their focus to providing holistic, community-based care, this employment program will address the underlying causes of poverty and provide resources to expand the community health workforce.

I strongly support this collaborative and innovative approach toward population-based health care and I hope you will give this proposal serious consideration. Thank you very much for your attention to this matter.

Sincerely,

C.A. Dutch Ruppersberger

C.A. Dutch Ruppersberger
Member of Congress

CADR:ng

JOHN P. SARBANES
3RD DISTRICT, MARYLAND

COMMITTEE ON
ENERGY AND COMMERCE

2444 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-4016
FAX: (202) 225-9219

Congress of the United States
House of Representatives
Washington, DC 20515–2003

www.sarbanes.house.gov

September 1, 2015

Mr. John Colmers
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215-2254

Dear Mr. Colmers:

I am writing to express my strong support for the proposal submitted to the Health Services Cost Review Commission (HSCRC) by Maryland's hospitals. The proposal will create a health employment program which will utilize funds to hire healthcare professionals from communities with high rates of poverty and unemployment within Baltimore City.

Tens of thousands of manufacturing jobs in the Baltimore metropolitan area have been lost over the last 40 years. This loss has resulted in a critical need of new entry level employment with opportunities for career advancement. This employment program will allow for the expansion of up to 1,000 hospital employed positions to be hired from low income, high unemployment areas. A hospital employment program that targets impoverished communities will improve the economic stability of the entire city.

The proposed employment program is consistent with the Maryland All-Payer Model Agreement that shifts hospital care towards a population health approach. Hospitals in Maryland are uniquely positioned to help in this process. While the program is intended to address the immediate issues facing Baltimore City, this endeavor will create a model that can be applied to any community in need of employment opportunities.

I ask that you give all appropriate consideration to the health employment program proposal to HSCRC.

Sincerely,

John P. Sarbanes
Member of Congress

JPS/jl

600 BALTIMORE AVENUE
SUITE 303
TOWSON, MD 21204
(410) 832-8890
FAX: (410) 832-8898

44 CALVERT STREET
SUITE 349
ANNAPOLIS, MD 21401
(410) 295-1679
FAX: (410) 295-1682

3901 NATIONAL DRIVE
SUITE 220
BURTONSVILLE, MD 20866
(301) 421-4078
FAX: (301) 421-4079

CHRIS VAN HOLLEN
8TH DISTRICT, MARYLAND

COMMITTEE ON THE BUDGET

Congress of the United States
House of Representatives
Washington, DC 20515

1707 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-5341

DISTRICT OFFICES:
51 MONROE STREET, #507
ROCKVILLE, MD 20850
(301) 424-3501

205 CENTER STREET
SUITE 206
MOUNT AIRY, MD 21771
(301) 829-2181

www.vanhollen.house.gov

August 26, 2015

Mr. John M. Colmers
Chairman
Maryland Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Chairman Colmers:

I am writing to express my strong support for the efforts of Johns Hopkins University Hospital and other Maryland hospitals to create a hospital-led employment program that hires residents of communities with high rates of poverty and unemployment.

Funding for this proposal will enable this collaborative hospital employment program to develop career pathways to jobs in the high growth healthcare industry for un- and under-employed Maryland residents of communities experiencing high rates of poverty. Hospitals provide a variety of entry-level positions that offer competitive salaries and benefits. Not only will this employment program improve the economic stability of the communities, but it will also have a positive impact on the overall health of these communities.

The proposed program is a collaborative and innovative approach toward population-based health care. I urge you to give it your most serious consideration.

Sincerely,

Chris Van Hollen
Member of Congress

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

THOMAS V. MIKE MILLER, JR.
PRESIDENT OF THE SENATE

MICHAEL E. BUSCH
SPEAKER OF THE HOUSE

THE MARYLAND GENERAL ASSEMBLY
STATE HOUSE
ANNAPOLIS, MARYLAND 21401-1991

September 9, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

As the presiding officers of the Maryland General Assembly, we offer our full support of the Hospital Employment Program.

The success of Maryland's unique hospital rate setting system is not only a source of pride for the State, it is also a platform for innovations that improve the health of Maryland's residents. We believe the Hospital Employment program represents a broad based collaboration that addresses the social and economic conditions that contribute to poor health. Creating an employment path for Maryland's most economically disadvantaged communities will not only bring stability and improved health to those communities but it will also improve the overall quality of living for all Marylanders.

We applaud all those involved in this innovative approach to population health. Thank you for your time and consideration.

Sincerely,

Thomas V. Mike Miller, Jr.
Senate President

Michael E. Busch
Speaker of the House

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

PETER A. HAMMEN
46th Legislative District
Baltimore City

Chair
Health and Government
Operations Committee

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 241
Annapolis, Maryland 21401
410-841-3770
800-492-7122 *Ext.* 3770

District Office
821 S. Grundy Street
Baltimore, Maryland 21224
410-342-3142

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

September 9, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

I am writing to express my strong support of the Hospital Employment Program. As Chairman of the House Health and Government Operations Committee, I work with committee members to shape health policy for our state. As we work to meet the goals of Maryland's All-Payer Model Agreement, we must look to new sources of partnership and innovation. The Hospital Employment Program aligns with the new All-Payer Model Agreement's focus on population health by creating community-based jobs targeting overall population health. This program utilizes our unique waiver system to improve economic and health outcomes for the pockets of Maryland that need stability most. As a representative of Baltimore City I welcome the opportunity to support a program poised to provide significant support to City residents. Additionally, this targeted employment program, focused on the State's most disadvantaged communities, has the potential to produce savings from improved overall community health.

The Maryland All-Payer Model Agreement provides Maryland with the unique opportunity for innovation. The Hospital Employment Program is a strong example of the type of collaboration we need to be successful under the new agreement. I strongly support this innovative approach to population health.

Sincerely,

Peter A. Hammen

Peter A. Hammen

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

MAGGIE MCINTOSH
Legislative District 43
Baltimore City

Chair
Appropriations Committee

The Maryland House of Delegates
6 Bladen Street, Room 121
Annapolis, Maryland 21401
410-841-3407 · 301-858-3407
800-492-7122 *Ext.* 3407
Fax 410-841-3416 · 301-858-3416
Maggie.McIntosh@house.state.md.us

The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

September 9, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

As Chair of the Maryland General Assembly House Committee on Appropriations, I am writing to express my support of the Hospital Employment Program. This program aims to improve the health, economy and stability of some of the state's most disadvantaged communities through a targeted employment program that offers hospital-based jobs to those who need them most.

The success of Maryland's unique hospital rate setting system is not only a source of pride for the State, it is also a platform for innovations that improve the health of Maryland's residents. I believe the Hospital Employment program represents a broad based collaboration that addresses the social and economic conditions that contribute to poor health. Creating an employment path for Maryland's most economically disadvantaged communities will not only bring stability and improved health to those communities but it will also improve the overall quality of living for all Marylanders. I applaud all those involved for this innovative approach to population health.

Sincerely,

Maggie L. McIntosh

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

STEPHANIE RAWLINGS-BLAKE
MAYOR

100 Holliday Street, Room 250
Baltimore, Maryland 21202

September 9, 2015

Mr. John M. Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, Maryland 21211

Dear Chairman Colmers:

I am writing to express my enthusiastic support of the Hospital Employment Program. This program represents the widespread collaboration between the City, the State, Maryland's hospitals, business leaders and insurers to address health and income disparities within the most disadvantaged communities. Given the number of qualifying zip codes that meet the criteria of the program, these efforts will make a substantial difference in improving the quality of life for may Baltimore City residents.

If you have any questions, please contact Kaliope Parthemos on (410) 396-4876 or Kaliope.parthemos@baltimoremorecity.gov .

Sincerely,

Stephanie Rawlings-Blake
Mayor
City of Baltimore

Cc: Kaliope Parthemos, Chief of Staff
Dr. Leana Wen, Baltimore City Health Commissioner
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

September 8, 2015

John M. Colmers
Chairman
The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

The Department has reviewed the Health Employment Program document prepared by the Maryland Hospital Association. In short, the proposal will build into hospital rates $40 million in additional funds to hire about 1,000 workers. The types of workers include community health workers, Medicaid and Health Benefit Exchange enrollment assistors, peer support specialists, as well as more traditional hospital employees, including environmental services, dietary staff, nursing assistants, escorts, and security personnel. We are writing to express our concern about the Health Employment Program and urge the HSCRC to conduct a comprehensive review of the hospital proposal before moving forward.

A Mechanism Already Exists for Funding this Initiative

The HSCRC has already made infrastructure adjustments to the hospitals rates totaling almost $200 million. These adjustments are not one-time adjustments; rather, they have been built permanently into hospital global budgets. Hospitals will receive these infrastructure monies every year unless the Commission takes action to end it.

The HSCRC built a 0.325 percent infrastructure adjustment into global budgets for FY 2014 and FY 2015, for a cumulative amount of roughly $100 million. Another 0.4 percent infrastructure adjustment was built into FY 2016 rates, and the hospitals have the potential to receive another 0.25 percent adjustment starting January 1, 2016. The additional 0.25 percent will be competitive, meaning that a hospital's ability to receive the additional 0.25 percent will depend on the quality of the hospital proposal or plan submitted on December 1, 2015. Nothing precludes the hospitals from submitting a proposal that includes a Health Employment Program. The estimated impact on the FY 2016 infrastructure adjustment is $100 million, meaning that in FY 2016 and every year thereafter, hospitals will receive $200 million in additional infrastructure monies.

Costs Will Not Be Offset Without Return on Investment from Hospital Global Budgets

We disagree that the savings will be largely offset from fewer people utilizing public programs such as Medicaid. Under federal eligibility requirements, and depending a number

of factors, including the income, cost of other coverage offered and household size of the individuals participating, they or their family members could remain eligible for Medicaid.

Additionally, during our Community Health Workers workgroup sessions, many participants questioned whether additional Community Health Workers would have the opposite effect on the Medicaid budget—that is, create more opportunities to enroll individuals on Medicaid. In the past, the Department has seen the utilization of Community Health Workers as a way to better coordinate care for our high cost populations more effectively. We believe, notwithstanding the potential outreach impact that additional Community Health Workers could result in additional savings to the overall program. A large component of those savings would come from hospital services. The proposal does not mention any of these savings being passed onto payers through a reduction in future hospital global budget revenues. Without a formula in place for payers to realize a return on investment accrued by the savings achieved by hospitals, there will be no offsetting of costs.

Applicants for the competitive 0.25 infrastructure rate increase are required to submit a calculation for the expected return on investment for their proposed interventions; should a separate Hospital Employment Program be created, it is the Department's position that a similar costing exercise should be produced.

Proposal Lacks Accountability to the Payers

The proposal outlines that hospitals receiving monies through the Health Employment Program will be required to submit biannual reports to HSCRC detailing the incremental employees hired and the costs associated with these hires. The proposal does not include a process where payers can provide feedback and recommendations on the new positions or the program in general. Medicaid pays for roughly 20 percent of hospital charges in Maryland. In other words, Medicaid will pay roughly $8 million of the $40 million proposal annually. The Department wants to ensure that an equal portion of any monies is devoted to employees who benefit the Medicaid population. The current proposal lacks this feedback mechanism or any measures to evaluate the program's impact.

The Department looks forward to working with the HSCRC on his important initiative. Please contact Shannon McMahon, Deputy Secretary of Health Care Financing at 410-767-5807 should you have any questions.

Sincerely,

Van T. Mitchell
Secretary

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

October 21, 2015

Mr. John Colmers
The Maryland Health Services
Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers,

I am writing to provide comments regarding the "Health Employment Program" (HEP) that was proposed by Johns Hopkins Hospital and other hospitals to the HSCRC on September 9, 2015.

As you know, the proposal would have the HSCRC put $40 million annually in additional funds into the rates of hospitals principally located in the city of Baltimore to fund approximately 1,000 additional jobs for disadvantaged inner city residents. While we certainly recognize the difficult economic and social circumstances that are challenging the inner city of Baltimore, we see this proposal as seriously flawed.

The following four points more specifically constitute our view of the proposal:

First, while the central purpose of the program is to increase employment opportunities for inner city residents with limited education and job experience, we question how the hospitals will use such individuals to provide needed capabilities. If the hospitals seek to hire more skilled and educated persons, this misses the target population most in need. Further, if the jobs to be created are really needed and are not simply "make work" jobs to fulfill a jobs program, then we question why the hospitals would not simply employ these individuals in the normal course of their operations.

Second, Johns Hopkins and the other hospitals have proposed a program of employment to which they would contribute no financial support. Instead they would pass the entire bill for the program along to other employers and individuals in the form of higher hospital rates (and ultimately health care premiums). With employers and individuals struggling to pay health care premiums, we think increasing their burden is not justified and we see no basis to believe that the expenditure of $40 million for the proposed jobs would result in equivalent or greater savings.

In effect, it would be like CareFirst suggesting it wanted to hire 1,000 new employees while handing the bill for this to Johns Hopkins and other hospitals. What at first seems like a virtuous attempt to fill a legitimate need becomes distinctly less so when one realizes that the sponsors intend others to pay for the program while paying nothing themselves.

Third, hospitals have been provided an increase of approximately $160M in rates to satisfy infrastructure changes under the new waiver model. If hospitals are committed to the dual objectives of improving community based care and raising employment levels in their communities, we ask why some of this additional funding would not be used for the achievement of these goals? This is particularly pertinent since all financial savings through lower utilization, improved community health, etc. will result in greater GBR savings that will accrue solely to the hospitals.

Fourth, since the advent of the new hospital all payer waiver in Maryland, hospital profit margins have soared to all time high levels on their regulated businesses. The hospitals suggest that the $40 million HEP is a small amount for the payers (ultimately employers and individuals) to bear. If the cost is so modest, why, we ask, could the hospitals not easily bear this small amount themselves out of the generous margins they are now enjoying? Indeed, we see the HEP as an activity that is consistent with the hospital's community benefit responsibilities. What, we would ask, holds them back - particularly in light of the large reductions in hospital charity care in recent years caused by ACA enrollment?

In sum, we believe that the proposed goal is laudable and that the funds for its achievement are available based on actions the HSCRC already has taken for the hospitals.

A proper judgment of this proposal turns not on the details of how it might be administered but rather, on the fact that its laudable purpose should be carried out in a fundamentally different way. Funding additional jobs by raising hospital rates is an unsound policy that has no obvious limits: if hospital rates can be raised to create jobs, why couldn't they be raised to fund myriad other social projects of greater or lesser merits?

The HSCRC's statutory role is to approve hospital rates that are consistent with the efficient and effective provision of hospital services. It is not the HSCRC's function to serve as the arbiter of resource expenditures in activities across a broad range of social purposes.

Sincerely,

Chet Burrell
President & CEO

cc Herbert Wong, PhD Vice Chairman
Stephen F. Jencks, MD
George H. Bone, MD
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Donna Kinzer, Executive Director
Van Mitchell, State of Maryland DHMH

BUILD
ROOTED IN COMMUNITY
COMMITTED TO CHANGE

October 14, 2015

Dr. Bernadette Loftus
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Dr. Loftus:

As Maryland's largest citizens' power organization representing more than 40 faith, school, and community institutions and over 20,000 members, Baltimoreans United in Leadership Development (BUILD) is asking for your support of the Healthcare Workers Opportunity Initiative. We believe this is a critical time in our city's history. We must act boldly to address the many issues of Baltimore city. This initiative is a major step in the right direction. It will create the opportunity to employ over 1,000 families in our city plus introduce families to more informative and engaged healthcare options and outcomes. We have listened to over 5,000 people across our city and overwhelmingly they have told us jobs is the most important issue facing their families.

BUILD has a 38 year track record of organizing to better Baltimore by winning the first living wage ordinance in the country, developing over 1200 affordable homes, and founding College Bound and the Child First Authority. Most recently, BUILD created Turn Around Tuesday to address the culture of violence in our City. Turn Around Tuesday is a jobs movement to help put Baltimore back to work by creating a jobs pipeline with hospitals, universities, and construction firms to hire returning citizens and residents living in distressed neighborhoods. Already, 74 men and women who had little to no opportunity for work have secured employment with an 89% six month retention rate. The unrest in Baltimore continues to galvanize us to create further opportunities with Baltimoreans.

BUILD is encouraged that area hospitals want to make a commitment to provide hiring opportunities, with training, and upward mobility within the health care field for area residents. Their proposal for a .25% rate increase to fund the hiring of 1,000 residents is promising. BUILD supports this proposal and asks you to join with us and stand for families all across our city.

Please contact BUILD Organizer, Terrell Williams, at 202-427-6876 or via email at novellae11@msn.com to schedule a meeting to discuss this important matter. We thank you in advance. BUILD looks forward to the opportunity to work with you to build a better Baltimore.

Sincerely,

Glenna Huber

Rev. Glenna Huber
BUILD Co Chair

Rev. Andrew Foster Connors
BUILD Co Chair

1199SEIU
United Healthcare Workers East

November 11, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

1199SEIU United Healthcare Workers East represents 9,000 healthcare workers throughout Maryland and the District of Columbia, many of whom live and work in Baltimore City. 1199SEIU represents workers at almost every stage of the health care delivery process, both in long term care facilities and hospitals. 1199SEIU also jointly operates a labor-management fund that provides educational and job training programs to eligible members. **It is with this expertise that we urge the Health Services Cost Review Commission (HSCRC) to consider our concerns and suggestions towards improving the proposed Health Job Opportunity Program currently under review - in the short term through this letter and in the future as a member of the potential program review panel and/or workgroup.**

Through their consideration of the proposal, the HSCRC acknowledged the role that the hospital industry plays in the economic well-being of Baltimore and its residents. The themes in the hospital's proposal are ones which our union has worked to highlight for many years. Our most recent and public evidence of this was our 2014 campaign to improve the economic security of workers at Johns Hopkins Hospital through wage increases designed to pull workers out of poverty. We have long advocated for improved wages and benefits for the workers at all levels of the healthcare workforce. Entry-level healthcare jobs MUST provide a meaningful pathway for workers to the middle class.

As mentioned above, our union also developed infrastructure and expertise in the details of workforce development. The 1199SEIU Training and Upgrading Fund (TUF) of the Maryland/DC region provides a safe and confidential space for union members to meet their educational goals. The Fund offers career and educational counseling services, coaching/case management, skill assessment, continuing education, tuition benefits and development of individual career and educational plans to thousands of 1199 members throughout the state.

We urge the HSCRC to consider that the systemic poverty which hospitals seek to address will not be solved by merely creating new jobs. The proposal as currently written suggests that the HSCRC establish a program review panel to determine which hospital applications should be funded. Should the HSCRC move forward with this proposal, we urge the Commission to include stakeholders who can offer guidance and expertise on the challenges faced by entry-level workers (such as our union's Training and Upgrading Fund) onto such a program review panel.

NEW YORK CITY PRINCIPAL HEADQUARTERS
310 West 43rd St.
New York, NY 10036
(212) 582-1890
www.1199seiu.org

ALBANY
155 Washington Ave.
Albany, NY 12210
Tel. (518) 396-2300
Fax (518) 438-1140

BALTIMORE, MARYLAND
611 North Eutaw Street
Baltimore, MD 21201
Tel. (410) 332-1199
Fax (410) 332-1895

MASSACHUSETTS
150 Mt. Vernon Street, 3rd Fl.
Dorchester, MA 02125
Tel. (617) 284-1199
Fax (617) 474-7150

BUFFALO
2421 Main Street, Suite 100
Buffalo, NY 14214
Tel. (716) 982-0540
Fax (716) 876-0930

FLORIDA
14645 NW 77th Avenue, Ste. #201
Miami Lakes, FL 33014
Tel. (305) 623-3000
Fax (305) 826-1604

GOUVERNEUR
95 E Main Street
Gouverneur, NY, 13642
Tel. (315) 287-9013
Fax (315) 287-7226

HICKSVILLE
100 Duffy Ave., Suite 3 West
Hicksville, NY 11801
Tel. (516) 542-1115
Fax (516) 542-0919

NEW JERSEY
555 Route 1 South, 3rd Fl.
Iselin, NJ 08830
Tel. (732) 287-8113
Fax (732) 287-8117

ROCHESTER
259 Monroe Ave., Suite 220
Rochester, NY 14607
Tel. (585) 244-0830
Fax (585) 244-0956

SYRACUSE
250 South Clinton, Suite 200
Syracuse, NY 13202
Tel. (315) 424-1743
Fax (315) 479-6716

WHITE PLAINS
99 Church St.
White Plains, NY 10601
Tel. (914) 993-6700
Fax (914) 993-6714

We also want to note that while hospitals have long been Baltimore City's largest employers, they are not traditionally viewed as experts in workforce development for the people who are being targeted in this proposed program. This program as designed requires hospitals to engage in a process that they have never been asked to engage in before. While some of the City's hospitals have embarked on relationships with community workforce organizations that assist individual employees in their career development goals, the sheer scale of what is being proposed requires hospitals to confront the challenges of workforce development in ways they have never had to in the past.

The Nurse Support I Program and the Nurse Support II Program (NSP Programs) have been cited as precedent for a collaborative response to this state's workforce crisis. While the NSP Programs have increased the number of nurses in Maryland, the workforce development strategies designed to address adults with limited education and income, or who live in high-poverty neighborhoods, are quite new to hospitals as employers.

We believe that hospitals must be able to provide specific details about what their outreach and retention strategies from low-income/high-unemployment zip codes would look like. And with the challenges of systemic poverty in mind, we propose to the HSCRC that in such a program, hospitals should detail the following:

- Assessment tools used by hospitals to identify candidates who will succeed. For example, how will the net be cast in poverty stricken communities to identify eligible workers? What will be the pre-requisite skills needed for workers to apply for these jobs? What assessment tools will be used to verify that the workers who are placed in these opportunities will succeed?
- Methods that will be used to train new entrants for the workforce. For example, will workers be trained cohort-style? Will they be grouped with incumbent workers? Details on how these workers will be trained will not only hold hospitals accountable, but also be useful for future evaluation of whether a specific hospital could retain workers, and why they were able to do so.
- Details about the case management and support systems that will be in place for workers to help them succeed. We have long heard from low-wage hospital workers on the difficulties they face utilizing education programs that exist in their institutions.

If the HSCRC were to move forward with this initiative, increased transparency would be critical to its success. For example, we believe that the HSCRC should collect demographic information about the participants in this program so that its strengths and weaknesses can be assessed in the future. Requiring submission of information such as the age range, education, prior experience and credentials of

workers who enter into hospital employment - and are retained –would also help stakeholders evaluate the program, adjust its goals and - ideally - replicate its success.

Should the HSCRC determine that further review and/or development of the proposal is required, we believe that our Training and Upgrading Fund could provide additional insight into the components required to initiate true workforce development that leads individuals towards economic stability and improves the health of our communities.

Sincerely,

Jen Brock-Cancellieri
Senior Policy Analyst
1199SEIU United Healthcare Workers East

The
League
of
Life and
Health
Insurers
of
Maryland

200 Duke of Gloucester Street
Annapolis, Maryland 21401
410-269-1554

November 13, 2015

John M. Colmers,
Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Hospital Job Opportunity Proposal

Dear Mr. Colmers:

The League of Life and Health Insurers of Maryland, Inc. (the League) is the trade association representing carriers who write life and health insurance in Maryland. Through our various membership categories, we work with every carrier writing major medical health insurance in this State. The League has had an opportunity to review the Health Employment Program proposal put forward by the Maryland Hospital Association and under consideration by the HSCRC. While we appreciate the effort to identify creative ways to address the daunting issue of poverty and unemployment in Baltimore and other areas of the State, especially as it relates to disadvantaged youth, for the reasons articulated below, we must oppose this program and urge the Commission to decline the request to support it through an increase in hospital rates.

Hospitals Have the Ability to Pay for the Program out of Existing Revenue Budgets

Two years into the implementation of the new waiver, hospitals are making record profits on regulated business – 5.86% for FY2015, up from 4.28% in FY2014. In fact, there are only five hospitals in the state that failed to realize a profit during that time period. In addition and more significantly, the HSCRC has already made infrastructure adjustments to the hospitals' rates totaling almost $200 million. These are not one-time adjustments; rather, they have been built permanently into hospital global budgets. That means unless the Commission takes action, hospitals will receive this money year after year. As a result, a portion of these funds could - and should- adequately fund this proposed program without the need for an additional increase.

Cost of Employment Programs for Hospital Workers Should Not be Born by Consumers and Businesses

Every additional increase to hospital rates has a direct impact on premiums paid by individuals, and employers - small and large, insured and self funded - in the State of Maryland. This proposal comes at a time of increased concern for rising insurance premiums, stringent Medical Loss Ratio requirements which must be met by carriers and a need to see a reduction of overall healthcare costs. At a time when all stakeholders in the health care community are working to

identify ways to reduce costs to the system, this program achieves the opposite effect, adding yet another layer of expense to premiums that have already experienced significant increases on average over the past several years.

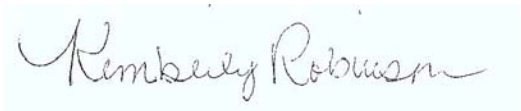
Using the Rate Setting System to Cover the Costs of an Employment Program Goes Beyond the Purposes of the Rate-Setting System

While there have been instances in the past where "employment" programs have been funded through hospital rates, those initiatives were on a much smaller scale with a purpose that more closely aligned with health care and the provision of clinical services. For example, the nursing support programs were created in response to a real, near crisis in the form of a nursing shortage. In addition, the average cost provided through rates to fund these nurse support programs was far less than $40 million annually – averaging closer to $10 million on an annual basis. While one can argue that community health workers may extend the ability of the hospitals to provide care to the community, the current proposal envisions hiring positions that go well beyond community health workers, to include general facility support such as janitors and security guards. All hospital related expenses necessary to satisfy current hospital service area populations are already currently funded in hospital rates.

The League supports the concept of this initiative which is intended to improve community health while addressing longstanding economic issues; however, as noted above, we cannot support the proposed funding arrangements which would increase hospital rates an additional $40 million to address issues that go beyond the scope of the all-payer system. Funding of jobs necessary to conduct hospital operations should be covered within the hospitals' current rate base. Any additional jobs should have a direct impact on a hospital's ability to improve population health and lower utilization of hospital services, all of which will improve hospitals' global budget savings.

For these reasons, we strongly urge the Commission to vote against any hospital rate increase to support this program.

Very truly yours,



Kimberly Y. Robinson, Esq,
Executive Director

Cc: Donna Kinzer, Executive Director, Health Services Cost Review Commission

BARBARA A. MIKULSKI
MARYLAND

United States Senate

WASHINGTON, DC 20510–2003

November 5, 2015

Mr. John M. Colmers
Chairman
The Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Colmers:

In September, you received a letter from me in support of an exciting and innovative new proposal from Maryland's hospitals, called the "Health Job Opportunity Program." This proposal, submitted to the Health Services Cost Review Commission (HSCRC), would create a hospital-led employment program to hire 1,000 additional people from Maryland communities with high rates of poverty and unemployment. I am so excited about the promise that this proposal has for our most distressed communities.

We have very real challenges facing Baltimore City that deserve more aggressive, comprehensive, and innovative solutions. The recent tragic death of Freddie Gray brought to light what many of us already knew to be true: we must address issues of social inequality in Baltimore City. The lack of stable, entry-level employment with opportunities for career advancement is a contributing factor to this social inequality. Unemployment contributes to poverty and poverty contributes to poor health. It is staggering that residents in Guilford have a life expectancy of nearly 20 years longer than residents of Greenmount East.

This is where the "Health Job Opportunity Program" could help play a pivotal role. As you know, Maryland's modernized all-payer waiver encourages hospitals to pursue creative solutions to improve the overall health and wellness of our communities. Since meaningful and stable employment can contribute to greater social and economic stability for underserved regions, and since hospitals have a role to play as some of our state's largest employers and community anchors, I am excited about what the "Health Job Opportunity Program" could mean to Baltimore City.

By creating this program – to allow for the expansion of up to 1,000 hospital-employed positions to be hired from low-income, high-unemployment areas – we could accomplish two important goals. First, by providing stable entry-level employment with advancement opportunities, we would be improving the overall socioeconomic determinants of health in distressed communities. And second, by expanding the community health workforce, we would assist Maryland's hospitals in providing health care to those in need.

I would urge the HSCRC to give the "Health Job Opportunity Program" every favorable consideration and stand ready to help in any way possible to get this proposal implemented on behalf of the people of Maryland. Thank you and please do not hesitate to contact me with any questions or concerns.

Sincerely,

Barbara A. Mikulski
United States Senator

Office of the President & CEO

Mercy
HEALTH SERVICES

University Affiliated

Sponsored by the Sisters of Mercy

November 17, 2015

Health Services Cost Review Commission (HSCRC)
C/O Donna Kinzer, Executive Director
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Response to Preliminary Staff Report on Health Job Opportunity Proposal

Dear Commissioners and Staff:

On behalf of Mercy Medical Center, this letter is to offer comment regarding the Health Services Cost Review Commission (HSCRC) preliminary staff recommendations on the Health Job Opportunity Program Proposal. Mercy Medical Center was proud to participate in the development of the proposal and supports the effort of expanding 1,000 hospital employed positions to be hired from low income, high unemployment areas for the purpose of: (1) Improving the overall socioeconomic determinants of health in the community and (2) Expanding the community health workforce to assist hospitals in improving population health.

As noted in the jobs program proposal, Baltimore and other parts of Maryland are especially challenged with high poverty rates which correlate to significant health disparities and poor health with higher costs to the health care system. The proposal represents a relatively small, targeted, and appropriate front-end investment to address the issue in a way that meets the triple aim of better care, better health, and lower costs. The proposal is aligned with Maryland's All-Payer model and should be viewed as complementary to other ongoing efforts in the state to improve public health and reduce health disparities while also recognizing that more work and investment is clearly needed.

Further, as large employers with existing, effective workforce development programs designed for entry-level and lower-skill workers, health systems are uniquely-positioned to expand career development opportunities through increased access to education, mentorship, and general skills-building. For example, at Mercy Medical Center we offer a host of programs specifically for this purpose including; tuition assistance, continuing education, computer training, GED preparation, literacy, and a comprehensive "Career Ladder" program that assists individuals in earning promotions and higher wages. The jobs program proposal would allow institutions like Mercy to expand these workforce development opportunities to more individuals in targeted communities while also supporting population health efforts.

Regarding the staff recommended options which seek to earmark dollars away from the Transformation Implementation Grants, Mercy agrees with our hospital partners who believe this approach would be disruptive to significant planning efforts already underway to respond to the Transformation Plan and RFP requirements.

345 St. Paul Place ◆ Baltimore, MD 21202-2123 ◆ (410) 332-9202 Fax (410) 962-1303
TTY (410) 332-9888

In conclusion, printed on the doors of our hospital is a welcome from the Sisters of Mercy and a declaration of a core belief to serve "all people of every creed, color, economic and social condition." We have carried on that principle for over 140 years in downtown Baltimore, especially during times of great challenge. With the April unrest, Baltimore has experienced a devastating manifestation of poverty, lack of access to jobs and upward mobility. We support jobs proposal to address the challenge while improving the health of our communities. Thank you for the opportunity to comment.

Sincerely,

Performance Measurement Workgroup Update

HSCRC Commission Meeting 11/18/2015

HSCRC
Health Services Cost Review Commission

Reviewed Guiding Principles For Performance-Based Payment Programs

- Program must improve care for all patients, regardless of payer
- Program incentives should support achievement of all payer model targets
- Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus
- Predetermined performance targets and financial impact
- Hospital ability to track progress
- Encourage cooperation and sharing of best practices
- Consider all settings of care

RY2018 Readmission Reduction Incentive Program Update Considerations

- Measure updates (e.g., planned admissions definitions, transfer logic)
- Medicare versus all payer rates
- Consideration of non-Maryland peer group rates
- Improvement target
- Payment adjustment structure and amounts
- Adjustments/protections based on socio-economic and other factors
- Draft recommendation in January 2016 and Final in February 2016

RY2018 MHAC Update Considerations

- Analysis of statistical validity and reliability and small hospital, small cell size issues
- Evaluation of PPC tier groups
- Setting the statewide target
- Maximum at risk determination
- Monitoring of ICD-10 Impact
- Draft recommendation in December 2015 and final in January 2016

Potentially Avoidable Utilization Measure

- Expanding the definition to other areas (9 Months)
  - Nursing home admissions
  - High risk patient utilization
  - Sepsis admissions
  - Avoidable Emergency Department Visits
- Risk adjusted measure of PAUs (18 months)

Efficiency Measure Considerations

- Measurement of Total Cost of Care (need all payer claims)
- Risk Adjustment
  - Demographics (Age, Sex, Social/economic factors)
  - Risk Adjustment Methodology
- Denominator
  - Virtual Patient Service Area
- Out of State Utilization Adjustment
- Benchmarks
- Timelines
  - Per Case measure revisions (next 3 months)
  - Per Capita Hospital Cost (next 9 months)
  - Per Capita Total Cost (next 18 months)

Key Strategic Considerations

- Prioritization
  - Leverage IT tools and measures
  - Use existing data and measures if possible
- Care coordination
  - Measures must be developed/adopted
  - Consider measures that are important to patients (functional status, quality of life)
- Condition-specific bundles
  - Target high cost, common procedures
  - Cut across measurement domains and settings of care
  - Consider "value"

Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2014

Heath Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605

November 2015

Executive Summary

The Maryland Health Services Cost Review Commission (HSCRC) has completed the annual hospital financial disclosure report for fiscal year (FY) 2014.

FY 2014 was a year of significant change for Maryland's hospital industry. Under the terms of a long-standing agreement with the federal government, Maryland sought to constrain the growth in the charge per case for Medicare inpatient hospital stays. Effective January 1, 2014, the State entered into a new agreement with the federal Centers for Medicare and Medicaid Services (CMS). 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 (combined inpatient and outpatient hospital costs) for all payers. The new Model will assess whether Maryland's all-payer system for hospital payments is a successful model for achieving the three-part aim of:

- Lower costs
- Better patient experience
- Improved health

Since FY 2014 straddles the January 2014 implementation date for the new waiver, this report focuses on performance on the new Model's financial and quality metrics, as well as traditional measures of hospital financial health.

This new report shows that for Maryland acute hospitals in FY 2014:

1) Gross all-payer per capita hospital revenues from services provided to Maryland residents grew 1.60 percent, slower than the per capita growth in the Maryland economy of about 2 percent in FY 2014.
2) Medicare fee-for-service hospital charges per Maryland Medicare beneficiary dropped 0.86 percent. Under the new waiver agreement with the federal government, Maryland must generate savings for Medicare by holding the growth in Medicare fee-for-service hospital payments below the national growth rate

during the five-year period of the waiver (calendar year [CY] 2014 through CY 2018). National data are not available for FY 2014, but CY 2014 data indicate that Maryland costs grew about two percentage points slower than the nation.

3) Profits on regulated activities increased in FY 2014, from $677 million (or 5.3 percent of regulated net operating revenue) in FY 2013 to $950 million (or 7.4 percent of regulated net operating revenue).

4) Profits on operations (which include profits and losses from regulated and *unregulated* day-to-day activities) increased from $164 million (or 1.2 percent of total net operating revenue) in FY 2013 to $424 million in FY 2014 (or 3.0 percent of total net operating revenue).

5) Total excess profits (which include profits and losses from regulated and unregulated operating and non-operating activities) increased substantially from $549 million in FY 2013 (or 3.8 percent of the total revenue) to $901 million in FY 2014 (or 6.1 percent of the total revenue).

6) Total regulated net patient revenue rose slightly from $12.5 billion in FY 2013 to $12.7 billion in FY 2014, an increase of 1.8 percent. If two hospitals that reported only 6 months of data in FY 2014 due to the conversion from a December 31 fiscal year end to a June 30 fiscal year end are removed from the calculation, then regulated net patient revenue grew from $12.2 billion in FY 2013 to $12.5 billion in FY 2014, an increase of 3.0 percent.

7) In 2014, Maryland hospitals incurred $1.0 billion in uncompensated care, approximately seven cents of uncompensated care cost for every dollar of gross patient revenue;.

8) Gross regulated revenue associated with potentially preventable complications (PPCs) occurring during a hospital admission declined from $391 million in FY 2013 to $292 million in FY 2014, a decrease of 25 percent. The gross regulated revenues from readmissions fell from $1.306 billion in FY 2013 to $1.285 billion in FY 2014. This decline in revenue reflects improvement in the quality of care

delivered in Maryland hospitals, where readmissions rates declined faster than the national levels for Medicare.

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 and 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 three-part 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 waiver is measured by:

- 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 hospital payments per beneficiary below the national Medicare per beneficiary fee-for-service growth rate. Maryland has committed to saving Medicare $330 million over five years by beating the national per capita hospital growth 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.

Since fiscal year (FY) 2014 straddles the January 2014 implementation date for the new waiver, this report focuses on performance on the new Model's financial and quality metrics, as well as traditional measures of hospital financial health. FY 2014 also marks a transition year for two hospitals (University of Maryland Upper Chesapeake and University of Maryland Harford Memorial) that changed from a December 31 fiscal year end to a June 30 fiscal year end. This transition results in those hospitals reporting 12 months of data for FY 2013 and 6 months for FY 2014. Unless noted in the text, all summary data referenced in the text include the FY 2013 and FY 2014 audited data submitted by these two hospitals. Statewide summary data are presented with and without the two hospitals in the tables on pages 1 and 1a of the data section of this report.

In contrast to prior disclosure reports, this report includes hospital level data on revenues associated with readmissions and other forms of potentially avoidable utilization (PAU). Readmission and PAU charges provides a financial indicator of opportunity for improvements in selected areas if we successfully transform health care for the benefit of the consumers. Reducing charges for PAU and readmissions will also free hospital resources for additional investments in health care transformation.

Despite implementing the new waiver agreement halfway into FY 2014, Maryland's performance on many of the new waiver metrics was favorable:

- All-payer per capita hospital revenues grew 1.60 percent, which is below both the per capita growth of the Maryland economy in both CY 2013 and CY 2014 and well below the 3.58 percent annual growth gap contained in the waiver agreement.
- Medicare fee-for-service hospital charges per Maryland Medicare beneficiary dropped 0.86 percent. National data are not available for FY 2014, but CY 2014 data indicate that Maryland costs grew about two percentage points slower than the nation.
- Gross regulated revenue associated with PPCs occurring during a hospital admission declined from $391 million in FY 2013 to $292 million in FY 2014, a decrease of 25 percent. This decline reflects improvement in the quality of care delivered in Maryland

hospitals. Gross regulated revenues from readmissions also dropped, falling from $1.306 billion in FY 2013 to $1.285 billion in FY 2014.

- Spending on PAU also dropped, falling from $2.253 billion in FY 2013 to $2.184 billion in FY 2014, a decrease of 3 percent.

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

- Gross regulated revenue growth. Gross patient revenue on regulated services increased 1.7 percent from $15.3 billion in FY 2013 to $15.5 billion in FY 2014.
- Net regulated patient revenue. Total regulated net patient revenue rose slightly from $12.5 billion in FY 2013 to $12.7 billion in FY 2014, an increase of 1.8 percent.
- Profits on regulated activities. Profits on regulated activities increased in FY 2014, from $677 million (5.3 percent of regulated net operating revenue) in FY 2013 to $950 million (7.4 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 $164 million (or 1.2 percent of total net operating revenue) in FY 2013 to $424 million in FY 2014 (or 3.0 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) increased substantially from $549 million in FY 2013 (or 3.8 percent of the total revenue) to $901 million in FY 2014 (or 6.1 percent of the total revenue).

In Maryland alone, 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 hospital costs and what hospitals ultimately charge patients—remained the lowest in the nation. The average mark up for hospitals nationally is more than 4.5 times that of Maryland Hospitals, according to the most recent data from the American Hospital Association (AHA). 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) has prepared comparative financial information from the respective hospitals.

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, were derived from the Annual Report of Revenue, Expenses, and Volumes (Annual Report) submitted to the HSCRC. 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, sale of cafeteria meals, gift shop sales, research, and 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.)

Potentially Avoidable Utilization (PAU) is the general classification of hospital care that is unplanned and can be prevented through improved care, care coordination, effective community based care, or care cost increases that result from a PPC occurring in a hospital. The HSCRC intends to continue to refine the measurement of PAU. 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 Maryland Readmission Reduction Incentive Program but applied to all inpatient discharges and observation stays greater than 23 hours.
- Prevention quality indicators (PQI) as defined by the Agency for Healthcare Research and Quality (AHRQ) applied to all inpatient discharges and observation stays greater than 23 hours. The PQIs included are the 12 acute and chronic PQIs included in the PQI-90 Composite measure and PQI 02 (Perforated Appendix). It does not include PQI 09 (low birth weight).

- 65 PPCs calculated under the Maryland Hospital Acquired Conditions Program and estimated average cost of PPCs.

Readmissions refer to the methodology for the readmission 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 APR-DRG Severity of Illness) and planned admissions.

Potentially Preventable Complications (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 (POA) 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.

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 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 abolished so that the physicians may bill fee-for-service.

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, Sheppard Pratt Hospital, St. Luke Institute, and University Specialty 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. University Specialty Hospital ceased operations effective August 1, 2012.

6. St. Luke Institute's license was changed from a specialty hospital to a residential treatment center and is no longer under the jurisdiction of the HSCRC.

7. Effective July 1, 2013, data associated with the University of Maryland Cancer Center was combined with that of the University of Maryland Medical Center.

8. Effective January 1, 2014, Levindale Hospital was designated by CMS as an acute care hospital, rather than a specialty hospital.

HEALTH SERVICES COST REVIEW COMMISSION

DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

FISCAL YEAR 2012 TO 2014

All Acute Hospitals

FISCAL YEAR ENDING	June 2014[1]	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	15,518,095,671	15,264,777,897	14,871,078,832
Unregulated Services	1,768,896,735	1,711,246,172	1,633,601,230
TOTAL	17,286,992,406	16,976,024,068	16,504,680,062
Net Patient Revenue (NPR):			
Regulated Services	12,728,114,584	12,507,457,797	12,275,982,668
Unregulated Services	800,936,290	784,503,042	791,489,147
TOTAL	13,529,050,874	13,291,960,839	13,067,471,815
Other Operating Revenue:			
Regulated Services	194,058,722	214,234,890	153,760,532
Unregulated Services	470,074,651	447,891,664	401,398,299
TOTAL	664,133,374	662,126,554	555,158,830
Net Operating Revenue (NOR)			
Regulated Services	12,922,173,306	12,721,692,687	12,429,743,200
Unregulated Services	1,271,010,942	1,232,394,706	1,192,887,446
Total	14,193,184,248	13,954,087,393	13,622,630,646
Total Operating Expenses:			
Regulated Services	11,971,929,258	12,044,797,691	11,649,000,119
Total	13,768,978,002	13,790,417,381	13,308,115,226
Net Operating Profit (Loss):			
Regulated Services	950,244,066	676,894,996	780,743,081
Unregulated Services	-526,037,747	-513,224,985	-466,227,662
Total	424,206,319	163,670,011	314,515,420
Total Non-Operating Profit (Loss):	476,672,214	379,251,306	-84,897,304
Non-Operating Revenue	494,572,512	393,729,556	81,100,427
Non-Operating Expenses	17,900,298	14,478,250	165,997,731
Total Excess Profit (Loss):	900,878,596	549,062,753	229,618,116
Total Regulated Inpatient Admissions:	580,552	616,184	638,274
Total Regulated Outpatient Visits:	4,946,138	4,832,757	4,898,998
Readmission Charges:	1,305,914,959	1,284,930,707	
Risk Adjusted Readmission Percent:	13.74%	13.52%	
Potentially Preventable Conditions (PPC) Costs	292,048,845	391,921,691	
Risk Adjusted PPC Rate:	1.03	1.36	
Potentially Avoidable Utilization Costs:	2,183,817,837	2,253,490,330	

[1] The totals for FY 2014 include 12 months for Levindale (now designated as an acute care hospital by CMS) and six (6) months for UM Harford Memorial and UM Upper Chesapeake, to accommodate changing from a December 31 fiscal year end to June 30 fiscal year end.

HEALTH SERVICES COST REVIEW COMMISSION

DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

FISCAL YEAR 2012 TO 2014 Page 1a

All Acute Hospitals

FISCAL YEAR ENDING	June 2014[2]	June 2013[3]	June 2012
Gross Patient Revenue:			
Regulated Services	15,306,904,471	14,871,277,796	14,871,078,832
Unregulated Services	1,768,718,935	1,710,888,872	1,633,601,230
TOTAL	17,075,623,406	16,582,166,668	16,504,680,062
Net Patient Revenue (NPR):			
Regulated Services	12,544,666,384	12,185,162,458	12,275,982,668
Unregulated Services	800,806,690	784,320,742	791,489,147
TOTAL	13,345,473,074	12,969,483,200	13,067,471,815
Other Operating Revenue:			
Regulated Services	192,065,322	208,843,890	153,760,532
Unregulated Services	468,623,952	444,769,664	401,398,299
TOTAL	660,689,275	653,613,554	555,158,831
Net Operating Revenue (NOR)			
Regulated Services	12,736,731,706	12,394,006,348	12,429,743,200
Unregulated Services	1,269,430,643	1,229,090,406	1,192,887,446
Total	14,006,162,349	13,623,096,754	13,622,630,646
Total Operating Expenses:			
Regulated Services	11,816,338,858	11,747,619,679	33,649,000,119
Total	13,606,104,402	13,481,889,082	35,308,115,226
Net Operating Profit (Loss):			
Regulated Services	920,392,866	646,386,669	780,743,081
Unregulated Services	-520,334,847	-505,178,997	-466,227,662
Total	400,058,019	141,207,672	314,515,419
Total Non-Operating Profit (Loss):	474,569,414	367,789,306	-84,897,304
Non-Operating Revenue	492,469,712	382,267,556	81,100,427
Non-Operating Expenses	17,900,298	14,478,250	165,997,731
Total Excess Profit (Loss):	874,627,496	515,138,414	229,618,116
Total Regulated Inpatient Admissions:	572,261	598,868	638,274
Total Regulated Outpatient Visits:	4,834,439	4,655,068	4,898,998

[2] The six (6) months from UM Harford Memorial and UM Upper Chesapeake have been removed from the FY 2014 totals for comparison purposes.

[3] The twelve (12) months of Harford Memorial and Upper Chesapeake have been removed from the FY 2013 totals for comparison.

Anne Arundel Medical Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	554,132,400	541,867,800	523,717,000
Unregulated Services	6,868,600	8,377,200	11,747,200
TOTAL	561,001,000	550,245,000	535,464,200
Net Patient Revenue (NPR):			
Regulated Services	451,481,300	444,013,900	435,998,560
Unregulated Services	6,553,400	7,464,500	8,958,100
TOTAL	458,034,700	451,478,400	444,956,660
Other Operating Revenue:			
Regulated Services	7,047,500	8,188,700	8,841,100
Unregulated Services	18,947,490	17,847,500	16,847,655
TOTAL	25,994,990	26,036,200	25,688,755
Net Operating Revenue (NOR)			
Regulated Services	458,528,800	452,202,600	444,839,660
Unregulated Services	25,500,890	25,312,000	25,805,755
Total	484,029,690	477,514,600	470,645,415
Total Operating Expenses:			
Regulated Services	433,202,797	436,200,149	421,842,523
Total	471,917,600	476,400,000	461,597,285
Net Operating Profit (Loss):			
Regulated Services	25,326,003	16,002,451	22,997,137
Unregulated Services	-13,213,903	-14,887,851	-13,949,007
Total	12,112,100	1,114,600	9,048,130
Total Non-Operating Profit (Loss):	27,091,100	44,226,600	-41,045,021
Non-Operating Revenue	27,091,100	44,226,600	-41,045,021
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	39,203,200	45,341,200	-31,996,892
Total Regulated Inpatient Admissions:	26,816	28,142	28,014
Total Regulated Outpatient Visits:	185,132	180,461	172,099

Readmission Charges:	29,937,886	32,221,736
Risk Adjusted Readmission Percent:	12.80%	12.68%
Potentially Preventable Conditions (PPC) Costs	9,612,798	10,811,675
Risk Adjusted PPC Rate:	1.04	1.16
Potentially Avoidable Utilization Costs:	58,578,209	63,462,083

Atlantic General Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	102,693,200	99,487,100	95,474,200
Unregulated Services	25,414,008	20,124,652	16,165,328
TOTAL	128,107,208	119,611,752	111,639,528
Net Patient Revenue (NPR):			
Regulated Services	83,845,400	81,125,900	77,261,700
Unregulated Services	13,780,408	11,081,452	9,419,228
TOTAL	97,625,808	92,207,352	86,680,928
Other Operating Revenue:			
Regulated Services	1,310,947	1,917,695	203,836
Unregulated Services	1,213,122	1,324,606	841,017
TOTAL	2,524,069	3,242,301	1,044,853
Net Operating Revenue (NOR)			
Regulated Services	85,156,347	83,043,595	77,465,536
Unregulated Services	14,993,530	12,406,058	10,260,245
Total	100,149,877	95,449,653	87,725,781
Total Operating Expenses:			
Regulated Services	76,554,862	73,821,246	69,630,609
Total	101,635,006	94,222,926	87,169,172
Net Operating Profit (Loss):			
Regulated Services	8,601,500	9,222,349	7,834,927
Unregulated Services	-10,086,613	-7,995,621	-7,278,318
Total	-1,485,113	1,226,727	556,609
Total Non-Operating Profit (Loss):	2,461,360	1,499,225	899,431
Non-Operating Revenue	2,461,360	1,499,225	899,431
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	976,248	2,725,952	1,456,040
Total Regulated Inpatient Admissions:	3,342	3,086	3,054
Total Regulated Outpatient Visits:	57,024	57,507	57,546
Readmission Charges:	6,536,496	6,803,892	
Risk Adjusted Readmission Percent:	12.85%	12.50%	
Potentially Preventable Conditions (PPC) Costs	1,168,922	1,018,245	
Risk Adjusted PPC Rate:	1.03	0.87	
Potentially Avoidable Utilization Costs:	13,229,885	13,145,463	

Bon Secours Hospital

FISCAL YEAR ENDING	August 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	129,714,300	121,044,100	130,651,800
Unregulated Services	26,341,350	27,611,031	29,355,513
TOTAL	156,055,650	148,655,131	160,007,313
Net Patient Revenue (NPR):			
Regulated Services	99,985,454	95,981,563	105,446,308
Unregulated Services	15,078,939	14,547,696	15,297,999
TOTAL	115,064,392	110,529,259	120,744,306
Other Operating Revenue:			
Regulated Services	1,585,024	-187,258	-311,199
Unregulated Services	4,245,338	3,163,706	3,352,382
TOTAL	5,830,362	2,976,447	3,041,184
Net Operating Revenue (NOR)			
Regulated Services	101,570,478	95,794,305	105,135,109
Unregulated Services	19,324,277	17,711,401	18,650,381
Total	120,894,754	113,505,706	123,785,490
Total Operating Expenses:			
Regulated Services	85,614,206	93,233,875	90,614,221
Total	118,891,000	124,525,202	122,564,724
Net Operating Profit (Loss):			
Regulated Services	15,956,273	2,560,429	14,520,888
Unregulated Services	-13,952,517	-13,579,925	-13,300,123
Total	2,003,755	-11,019,496	1,220,765
Total Non-Operating Profit (Loss):	1,565,750	1,392,305	383,037
Non-Operating Revenue	1,565,750	1,435,493	387,108
Non-Operating Expenses	0	43,188	4,072
Total Excess Profit (Loss):	3,569,505	-9,627,191	1,603,802
Total Regulated Inpatient Admissions:	4,660	5,894	6,579
Total Regulated Outpatient Visits:	37,681	41,340	40,473
Readmission Charges:	25,891,416	23,402,406	
Risk Adjusted Readmission Percent:	19.35%	19.32%	
Potentially Preventable Conditions (PPC) Costs	1,457,874	2,774,845	
Risk Adjusted PPC Rate:	0.69	1.35	
Potentially Avoidable Utilization Costs:	36,187,844	34,240,166	

Bowie Emergency Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	16,513,400	13,677,900	11,999,900
Unregulated Services	9,852,802	16,278,037	18,286,174
TOTAL	26,366,202	29,955,937	30,286,074
Net Patient Revenue (NPR):			
Regulated Services	12,399,706	9,812,164	8,676,283
Unregulated Services	4,648,934	5,639,207	7,121,389
TOTAL	17,048,641	15,451,371	15,797,672
Other Operating Revenue:			
Regulated Services	867	7,168	13,057
Unregulated Services	0	0	0
TOTAL	867	7,168	13,057
Net Operating Revenue (NOR)			
Regulated Services	12,400,574	9,819,332	8,689,340
Unregulated Services	4,648,934	5,639,207	7,121,389
Total	17,049,508	15,458,539	15,810,729
Total Operating Expenses:			
Regulated Services	10,457,177	10,764,397	9,256,547
Total	15,071,710	16,611,645	16,353,968
Net Operating Profit (Loss):			
Regulated Services	1,943,397	-945,065	-567,207
Unregulated Services	34,401	-208,041	23,968
Total	1,977,798	-1,153,106	-543,239
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	1,977,798	-1,153,106	-543,239
Total Regulated Inpatient Admissions:	0	0	0
Total Regulated Outpatient Visits:	35,566	36,040	35,932

Calvert Memorial Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	141,935,300	138,862,900	135,740,500
Unregulated Services	10,240,860	9,162,932	17,105,738
TOTAL	152,176,160	148,025,832	152,846,238
Net Patient Revenue (NPR):			
Regulated Services	117,478,592	116,275,170	112,025,692
Unregulated Services	4,675,516	4,562,155	13,276,082
TOTAL	122,154,108	120,837,325	125,301,775
Other Operating Revenue:			
Regulated Services	5,148,688	4,305,853	3,698,312
Unregulated Services	952,342	663,940	1,480,473
TOTAL	6,101,030	4,969,793	5,178,786
Net Operating Revenue (NOR)			
Regulated Services	122,627,280	120,581,023	115,724,005
Unregulated Services	5,627,858	5,226,095	14,756,556
Total	128,255,139	125,807,118	130,480,560
Total Operating Expenses:			
Regulated Services	105,829,305	106,039,515	105,451,118
Total	119,797,306	118,896,903	130,770,372
Net Operating Profit (Loss):			
Regulated Services	16,797,976	14,541,508	10,272,886
Unregulated Services	-8,340,143	-7,631,293	-10,562,698
Total	8,457,833	6,910,215	-289,812
Total Non-Operating Profit (Loss):	-1,655,105	6,414	3,063,317
Non-Operating Revenue	514,608	504,618	3,063,317
Non-Operating Expenses	2,169,713	498,204	0
Total Excess Profit (Loss):	6,802,728	6,916,629	2,773,506
Total Regulated Inpatient Admissions:	5,756	6,835	7,405
Total Regulated Outpatient Visits:	65,430	30,762	67,610

Readmission Charges:	6,912,639	7,732,586
Risk Adjusted Readmission Percent:	9.27%	10.37%
Potentially Preventable Conditions (PPC) Costs	1,238,388	2,462,748
Risk Adjusted PPC Rate:	0.87	1.33
Potentially Avoidable Utilization Costs:	16,559,469	18,957,422

Carroll County General Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	251,985,400	249,075,200	243,424,400
Unregulated Services	74,612,637	77,746,543	74,684,611
TOTAL	326,598,037	326,821,743	318,109,011
Net Patient Revenue (NPR):			
Regulated Services	211,421,290	208,787,942	203,507,315
Unregulated Services	33,726,861	36,390,537	34,947,553
TOTAL	245,148,151	245,178,479	238,454,868
Other Operating Revenue:			
Regulated Services	4,639,865	3,551,806	959,950
Unregulated Services	961,456	905,052	874,246
TOTAL	5,601,321	4,456,858	1,834,196
Net Operating Revenue (NOR)			
Regulated Services	216,061,155	212,339,748	204,467,265
Unregulated Services	34,688,317	37,295,589	35,821,799
Total	250,749,472	249,635,337	240,289,064
Total Operating Expenses:			
Regulated Services	189,824,332	187,052,755	182,701,684
Total	229,948,414	229,386,050	223,442,869
Net Operating Profit (Loss):			
Regulated Services	26,236,823	25,286,993	21,765,581
Unregulated Services	-5,435,765	-5,037,706	-4,919,386
Total	20,801,058	20,249,287	16,846,195
Total Non-Operating Profit (Loss):	6,354,928	10,424,416	-11,976,079
Non-Operating Revenue	9,594,707	11,480,669	1,813,742
Non-Operating Expenses	3,239,779	1,056,253	13,789,821
Total Excess Profit (Loss):	27,155,986	30,673,703	4,870,116
Total Regulated Inpatient Admissions:	11,220	11,585	12,276
Total Regulated Outpatient Visits:	88,578	89,538	87,911
Readmission Charges:	23,043,606	22,341,916	
Risk Adjusted Readmission Percent:	13.38%	12.48%	
Potentially Preventable Conditions (PPC) Costs	5,232,274	5,035,941	
Risk Adjusted PPC Rate:	1.14	1.13	
Potentially Avoidable Utilization Costs:	42,072,962	41,334,083	

Doctors Community Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	222,145,400	216,854,500	214,285,300
Unregulated Services	21,497,124	15,472,076	14,287,965
TOTAL	243,642,524	232,326,576	228,573,265
Net Patient Revenue (NPR):			
Regulated Services	178,102,639	171,977,743	176,759,733
Unregulated Services	21,502,253	15,430,295	14,210,549
TOTAL	199,604,892	187,408,037	190,970,282
Other Operating Revenue:			
Regulated Services	2,232,490	5,842,396	118,417
Unregulated Services	3,242,342	3,333,007	6,543,172
TOTAL	5,474,832	9,175,403	6,661,589
Net Operating Revenue (NOR)			
Regulated Services	180,335,129	177,820,138	176,878,150
Unregulated Services	24,744,595	18,763,302	20,753,721
Total	205,079,724	196,583,440	197,631,871
Total Operating Expenses:			
Regulated Services	170,083,752	173,397,492	170,336,837
Total	204,184,713	199,300,918	197,169,715
Net Operating Profit (Loss):			
Regulated Services	10,251,378	4,422,646	6,541,312
Unregulated Services	-9,356,366	-7,140,124	-6,079,156
Total	895,012	-2,717,478	462,156
Total Non-Operating Profit (Loss):	-243,211	1,302,400	-156,352
Non-Operating Revenue	-243,211	1,302,400	440,832
Non-Operating Expenses	0	0	597,184
Total Excess Profit (Loss):	651,801	-1,415,078	305,804
Total Regulated Inpatient Admissions:	9,709	10,857	12,052
Total Regulated Outpatient Visits:	68,199	62,700	97,540
Readmission Charges:	25,008,330	26,574,120	
Risk Adjusted Readmission Percent:	12.98%	12.96%	
Potentially Preventable Conditions (PPC) Costs	5,122,391	7,660,078	
Risk Adjusted PPC Rate:	1.16	1.55	
Potentially Avoidable Utilization Costs:	46,457,473	49,789,285	

Fort Washington Medical Center

FISCAL YEAR ENDING	December 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	48,565,970	46,156,625	46,176,442
Unregulated Services	404,675	391,018	565,184
TOTAL	48,970,645	46,547,643	46,741,626
Net Patient Revenue (NPR):			
Regulated Services	40,450,576	37,357,875	37,540,675
Unregulated Services	404,675	391,018	565,184
TOTAL	40,855,251	37,748,893	38,105,859
Other Operating Revenue:			
Regulated Services	1,345,091	1,717,070	1,761,701
Unregulated Services	39,088	41,245	39,910
TOTAL	1,384,179	1,758,315	1,801,611
Net Operating Revenue (NOR)			
Regulated Services	41,795,667	39,074,945	39,302,376
Unregulated Services	443,763	432,263	605,094
Total	42,239,430	39,507,208	39,907,470
Total Operating Expenses:			
Regulated Services	39,766,800	37,851,168	37,600,240
Total	40,859,285	38,931,926	38,806,268
Net Operating Profit (Loss):			
Regulated Services	2,028,867	1,223,777	1,702,136
Unregulated Services	-648,722	-648,495	-600,935
Total	1,380,145	575,282	1,101,202
Total Non-Operating Profit (Loss):	607	748	808
Non-Operating Revenue	607	748	808
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	1,380,752	576,030	1,102,010
Total Regulated Inpatient Admissions:	2,177	2,306	2,185
Total Regulated Outpatient Visits:	43,635	42,300	45,263
Readmission Charges:	4,759,174	3,998,744	
Risk Adjusted Readmission Percent:	15.03%	14.69%	
Potentially Preventable Conditions (PPC) Costs	458,010	620,940	
Risk Adjusted PPC Rate:	0.77	1.31	
Potentially Avoidable Utilization Costs:	9,249,582	8,695,159	

Frederick Memorial Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	339,660,800	337,093,700	334,410,300
Unregulated Services	69,997,055	98,857,274	93,637,680
TOTAL	409,657,855	435,950,974	428,047,980
Net Patient Revenue (NPR):			
Regulated Services	274,540,716	276,164,675	267,942,036
Unregulated Services	38,893,323	54,480,258	59,840,190
TOTAL	313,434,038	330,644,933	327,782,227
Other Operating Revenue:			
Regulated Services	6,545,338	5,039,603	4,765,628
Unregulated Services	3,683,661	4,678,290	4,623,611
TOTAL	10,228,999	9,717,893	9,389,239
Net Operating Revenue (NOR)			
Regulated Services	281,086,054	281,204,278	272,707,664
Unregulated Services	42,576,984	59,158,548	64,463,802
Total	323,663,037	340,362,826	337,171,466
Total Operating Expenses:			
Regulated Services	264,760,912	263,988,130	263,435,625
Total	320,533,000	340,965,873	336,582,000
Net Operating Profit (Loss):			
Regulated Services	16,325,142	17,216,148	9,272,039
Unregulated Services	-13,195,104	-17,819,196	-8,682,574
Total	3,130,038	-603,048	589,466
Total Non-Operating Profit (Loss):	13,863,000	11,341,981	-3,588,239
Non-Operating Revenue	16,523,000	14,535,107	4,221,761
Non-Operating Expenses	2,660,000	3,193,127	7,810,000
Total Excess Profit (Loss):	16,993,038	10,738,933	-2,998,773
Total Regulated Inpatient Admissions:	16,383	17,954	19,107
Total Regulated Outpatient Visits:	118,058	103,642	100,619
Readmission Charges:	24,352,223	26,296,569	
Risk Adjusted Readmission Percent:	11.38%	11.04%	
Potentially Preventable Conditions (PPC) Costs	5,523,089	7,880,262	
Risk Adjusted PPC Rate:	0.93	1.21	
Potentially Avoidable Utilization Costs:	47,347,569	51,962,805	

Garrett County Memorial Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	45,202,600	42,302,400	42,709,900
Unregulated Services	7,013,510	8,618,007	7,931,586
TOTAL	52,216,110	50,920,407	50,641,486
Net Patient Revenue (NPR):			
Regulated Services	36,914,781	34,358,738	33,399,378
Unregulated Services	4,252,165	5,094,768	4,881,490
TOTAL	41,166,947	39,453,506	38,280,868
Other Operating Revenue:			
Regulated Services	1,918,578	727,876	334,136
Unregulated Services	299,663	267,413	302,418
TOTAL	2,218,241	995,289	636,554
Net Operating Revenue (NOR)			
Regulated Services	38,833,359	35,086,614	33,733,514
Unregulated Services	4,551,828	5,362,181	5,183,908
Total	43,385,188	40,448,795	38,917,422
Total Operating Expenses:			
Regulated Services	34,661,815	32,516,478	31,978,077
Total	40,023,965	39,162,664	37,720,740
Net Operating Profit (Loss):			
Regulated Services	4,171,544	2,570,135	1,755,437
Unregulated Services	-810,322	-1,284,004	-558,755
Total	3,361,223	1,286,131	1,196,682
Total Non-Operating Profit (Loss):	877,732	754,939	425,243
Non-Operating Revenue	877,732	754,939	601,391
Non-Operating Expenses	0	0	176,148
Total Excess Profit (Loss):	4,238,955	2,041,070	1,621,925
Total Regulated Inpatient Admissions:	1,865	2,009	2,177
Total Regulated Outpatient Visits:	23,401	26,559	24,428
Readmission Charges:	1,527,265	2,124,416	
Risk Adjusted Readmission Percent:	7.82%	8.53%	
Potentially Preventable Conditions (PPC) Costs	380,113	382,656	
Risk Adjusted PPC Rate:	1.15	0.96	
Potentially Avoidable Utilization Costs:	4,824,184	5,108,663	

Germantown Emergency Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	14,059,900	12,992,000	14,429,600
Unregulated Services	0	0	0
TOTAL	14,059,900	12,992,000	14,429,600
Net Patient Revenue (NPR):			
Regulated Services	9,216,478	9,389,152	10,350,133
Unregulated Services	0	0	0
TOTAL	9,216,478	9,389,152	10,350,133
Other Operating Revenue:			
Regulated Services	7,567	14,865	20,575
Unregulated Services	263,000	0	0
TOTAL	270,567	14,865	20,575
Net Operating Revenue (NOR)			
Regulated Services	9,224,045	9,404,017	10,370,708
Unregulated Services	263,000	0	0
Total	9,487,045	9,404,017	10,370,708
Total Operating Expenses:			
Regulated Services	11,106,309	11,094,387	10,402,573
Total	11,406,414	11,289,944	10,758,951
Net Operating Profit (Loss):			
Regulated Services	-1,882,264	-1,690,370	-31,865
Unregulated Services	-37,105	-195,557	-356,378
Total	-1,919,369	-1,885,927	-388,243
Total Non-Operating Profit (Loss):	-407,785	-378,665	-338,377
Non-Operating Revenue	-407,785	-378,665	-338,377
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-2,327,154	-2,264,592	-726,620
Total Regulated Inpatient Admissions:	0	0	0
Total Regulated Outpatient Visits:	34,623	34,599	33,815

Greater Baltimore Medical Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	426,965,000	421,137,700	426,432,400
Unregulated Services	46,343,000	44,910,725	43,504,800
TOTAL	473,308,000	466,048,425	469,937,200
Net Patient Revenue (NPR):			
Regulated Services	357,329,000	352,971,792	357,119,673
Unregulated Services	21,736,100	21,816,956	21,597,046
TOTAL	379,065,100	374,788,748	378,716,719
Other Operating Revenue:			
Regulated Services	8,765,799	7,062,683	8,535,246
Unregulated Services	14,711,200	12,145,411	10,795,400
TOTAL	23,476,999	19,208,094	19,330,646
Net Operating Revenue (NOR)			
Regulated Services	366,094,799	360,034,475	365,654,919
Unregulated Services	36,447,300	33,962,367	32,392,446
Total	402,542,099	393,996,842	398,047,365
Total Operating Expenses:			
Regulated Services	335,132,100	330,512,612	339,031,966
Total	381,697,400	379,062,165	384,772,902
Net Operating Profit (Loss):			
Regulated Services	30,962,700	29,521,863	26,622,953
Unregulated Services	-10,118,000	-14,587,186	-13,348,490
Total	20,844,700	14,934,677	13,274,463
Total Non-Operating Profit (Loss):	19,695,000	18,295,933	5,101,873
Non-Operating Revenue	20,282,900	18,792,504	6,816,966
Non-Operating Expenses	587,900	496,571	1,715,093
Total Excess Profit (Loss):	40,539,700	33,230,610	18,376,336
Total Regulated Inpatient Admissions:	16,896	17,180	18,386
Total Regulated Outpatient Visits:	104,016	101,310	103,539
Readmission Charges:	23,875,059	24,069,438	
Risk Adjusted Readmission Percent:	11.51%	11.59%	
Potentially Preventable Conditions (PPC) Costs	7,447,441	10,210,625	
Risk Adjusted PPC Rate:	1.15	1.60	
Potentially Avoidable Utilization Costs:	46,187,057	49,363,397	

Holy Cross Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	468,876,700	461,351,200	453,731,600
Unregulated Services	28,978,500	28,420,055	26,444,000
TOTAL	497,855,200	489,771,255	480,175,600
Net Patient Revenue (NPR):			
Regulated Services	382,981,000	373,367,100	362,831,800
Unregulated Services	14,213,000	13,422,946	12,252,600
TOTAL	397,194,000	386,790,046	375,084,400
Other Operating Revenue:			
Regulated Services	6,272,300	6,119,000	4,593,400
Unregulated Services	10,731,690	11,136,000	11,802,100
TOTAL	17,003,990	17,255,000	16,395,500
Net Operating Revenue (NOR)			
Regulated Services	389,253,300	379,486,100	367,425,200
Unregulated Services	24,944,690	24,558,946	24,054,700
Total	414,197,990	404,045,046	391,479,900
Total Operating Expenses:			
Regulated Services	348,206,775	336,499,534	325,133,202
Total	390,903,000	379,895,000	364,822,000
Net Operating Profit (Loss):			
Regulated Services	41,046,525	42,986,566	42,291,998
Unregulated Services	-17,751,525	-18,836,520	-15,634,098
Total	23,295,000	24,150,046	26,657,900
Total Non-Operating Profit (Loss):	23,263,000	13,278,000	-580,000
Non-Operating Revenue	23,263,000	13,278,000	-580,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	46,558,000	37,428,046	26,077,900
Total Regulated Inpatient Admissions:	27,507	27,676	27,918
Total Regulated Outpatient Visits:	114,641	121,384	122,355
Readmission Charges:	39,862,724	36,734,667	
Risk Adjusted Readmission Percent:	12.72%	12.17%	
Potentially Preventable Conditions (PPC) Costs	10,526,156	11,557,939	
Risk Adjusted PPC Rate:	1.18	1.26	
Potentially Avoidable Utilization Costs:	69,379,005	65,899,561	

Howard County General Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	281,805,600	278,901,600	275,201,900
Unregulated Services	0	0	0
TOTAL	281,805,600	278,901,600	275,201,900
Net Patient Revenue (NPR):			
Regulated Services	232,598,600	232,449,101	228,528,424
Unregulated Services	0	0	0
TOTAL	232,598,600	232,449,101	228,528,424
Other Operating Revenue:			
Regulated Services	62,249	99,739	75,986
Unregulated Services	1,995,674	1,681,428	1,921,290
TOTAL	2,057,923	1,781,167	1,997,276
Net Operating Revenue (NOR)			
Regulated Services	232,660,849	232,548,840	228,604,410
Unregulated Services	1,995,674	1,681,428	1,921,290
Total	234,656,523	234,230,268	230,525,700
Total Operating Expenses:			
Regulated Services	222,265,553	214,010,558	210,259,612
Total	231,079,634	223,533,128	220,890,194
Net Operating Profit (Loss):			
Regulated Services	10,395,296	18,538,282	18,344,798
Unregulated Services	-6,818,406	-7,841,142	-8,709,292
Total	3,576,890	10,697,140	9,635,506
Total Non-Operating Profit (Loss):	6,309,706	8,692,566	-10,905,869
Non-Operating Revenue	4,133,076	1,763,387	2,601,476
Non-Operating Expenses	-2,176,630	-6,929,179	13,507,345
Total Excess Profit (Loss):	9,886,601	19,389,706	-1,270,363
Total Regulated Inpatient Admissions:	16,270	16,001	15,680
Total Regulated Outpatient Visits:	104,460	102,700	106,272
Readmission Charges:	26,597,084	25,008,934	
Risk Adjusted Readmission Percent:	13.28%	12.43%	
Potentially Preventable Conditions (PPC) Costs	6,201,772	7,789,046	
Risk Adjusted PPC Rate:	1.27	1.57	
Potentially Avoidable Utilization Costs:	46,291,094	47,849,825	

Johns Hopkins Bayview Medical Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	605,106,300	596,807,300	584,860,100
Unregulated Services	4,406,900	8,573,900	9,292,400
TOTAL	609,513,200	605,381,200	594,152,500
Net Patient Revenue (NPR):			
Regulated Services	484,348,000	476,903,000	464,656,600
Unregulated Services	3,663,900	8,006,900	8,655,400
TOTAL	488,011,900	484,909,900	473,312,000
Other Operating Revenue:			
Regulated Services	9,049,099	9,832,500	10,640,600
Unregulated Services	42,960,500	38,516,600	40,589,600
TOTAL	52,009,599	48,349,100	51,230,200
Net Operating Revenue (NOR)			
Regulated Services	493,397,099	486,735,500	475,297,200
Unregulated Services	46,624,400	46,523,500	49,245,000
Total	540,021,499	533,259,000	524,542,200
Total Operating Expenses:			
Regulated Services	472,155,588	480,902,619	453,372,164
Total	530,603,000	541,313,000	515,400,000
Net Operating Profit (Loss):			
Regulated Services	21,241,512	5,832,881	21,925,036
Unregulated Services	-11,823,012	-13,886,881	-12,782,836
Total	9,418,500	-8,054,000	9,142,200
Total Non-Operating Profit (Loss):	1,686,500	1,258,000	1,483,500
Non-Operating Revenue	1,686,500	1,258,000	1,483,500
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	11,105,000	-6,796,000	10,625,700
Total Regulated Inpatient Admissions:	20,529	21,497	21,903
Total Regulated Outpatient Visits:	440,573	434,814	458,827
Readmission Charges:	50,884,040	51,725,255	
Risk Adjusted Readmission Percent:	16.05%	15.72%	
Potentially Preventable Conditions (PPC) Costs	7,556,155	15,218,356	
Risk Adjusted PPC Rate:	0.83	1.62	
Potentially Avoidable Utilization Costs:	81,149,306	89,464,625	

Johns Hopkins Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	2,172,517,900	2,132,419,000	1,851,351,500
Unregulated Services	12,351,327	7,919,391	7,839,714
TOTAL	2,184,869,227	2,140,338,391	1,859,191,214
Net Patient Revenue (NPR):			
Regulated Services	1,778,796,357	1,760,717,473	1,578,655,727
Unregulated Services	10,509,115	6,115,491	6,586,531
TOTAL	1,789,305,472	1,766,832,964	1,585,242,258
Other Operating Revenue:			
Regulated Services	14,656,180	14,570,644	14,097,472
Unregulated Services	155,742,900	131,724,408	124,914,611
TOTAL	170,399,080	146,295,052	139,012,083
Net Operating Revenue (NOR)			
Regulated Services	1,793,452,537	1,775,288,117	1,592,753,199
Unregulated Services	166,252,015	137,839,899	131,501,142
Total	1,959,704,552	1,913,128,016	1,724,254,341
Total Operating Expenses:			
Regulated Services	1,768,501,426	1,757,360,894	1,560,026,965
Total	1,928,276,090	1,897,159,817	1,690,861,340
Net Operating Profit (Loss):			
Regulated Services	24,951,117	17,927,223	32,726,234
Unregulated Services	6,477,361	-1,959,024	666,767
Total	31,428,478	15,968,199	33,393,001
Total Non-Operating Profit (Loss):	35,421,690	35,094,878	32,718,682
Non-Operating Revenue	35,421,690	35,094,878	32,718,682
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	66,850,174	51,063,077	66,111,683
Total Regulated Inpatient Admissions:	48,466	48,261	47,047
Total Regulated Outpatient Visits:	548,274	536,188	499,124
Readmission Charges:	172,736,442	169,582,297	
Risk Adjusted Readmission Percent:	15.64%	15.00%	
Potentially Preventable Conditions (PPC) Costs	35,869,802	60,288,690	
Risk Adjusted PPC Rate:	0.98	1.64	
Potentially Avoidable Utilization Costs:	221,715,714	239,682,555	

Laurel Regional Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	118,865,000	121,542,100	118,724,400
Unregulated Services	5,189,156	3,766,780	3,961,730
TOTAL	124,054,156	125,308,880	122,686,130
Net Patient Revenue (NPR):			
Regulated Services	97,912,231	98,649,934	93,954,841
Unregulated Services	1,501,121	1,477,821	1,273,246
TOTAL	99,413,352	100,127,755	95,228,087
Other Operating Revenue:			
Regulated Services	2,735,242	118,373	-189,126
Unregulated Services	306,036	283,265	249,353
TOTAL	3,041,278	401,638	60,227
Net Operating Revenue (NOR)			
Regulated Services	100,647,473	98,768,306	93,765,714
Unregulated Services	1,807,157	1,761,086	1,522,599
Total	102,454,630	100,529,393	95,288,314
Total Operating Expenses:			
Regulated Services	104,245,610	101,679,156	96,874,582
Total	111,690,619	110,799,556	104,340,682
Net Operating Profit (Loss):			
Regulated Services	-3,598,137	-2,910,849	-3,108,868
Unregulated Services	-5,637,852	-7,359,314	-5,943,501
Total	-9,235,989	-10,270,163	-9,052,368
Total Non-Operating Profit (Loss):	8,550,000	8,700,000	9,150,000
Non-Operating Revenue	8,550,000	8,700,000	9,150,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-685,989	-1,570,163	97,632
Total Regulated Inpatient Admissions:	5,494	5,989	5,630
Total Regulated Outpatient Visits:	47,120	51,767	49,270
Readmission Charges:	10,415,185	10,515,640	
Risk Adjusted Readmission Percent:	14.63%	13.96%	
Potentially Preventable Conditions (PPC) Costs	1,619,668	1,704,415	
Risk Adjusted PPC Rate:	1.03	0.91	
Potentially Avoidable Utilization Costs:	17,174,878	17,074,036	

Levindale[4]

FISCAL YEAR ENDING	June 2014
Gross Patient Revenue:	
Regulated Services	54,541,800
Unregulated Services	35,343,587
TOTAL	89,885,387
Net Patient Revenue (NPR):	
Regulated Services	47,571,840
Unregulated Services	28,791,830
TOTAL	76,363,670
Other Operating Revenue:	
Regulated Services	1,640,083
Unregulated Services	54,975
TOTAL	1,695,058
Net Operating Revenue (NOR)	
Regulated Services	49,211,923
Unregulated Services	28,846,805
Total	78,058,728
Total Operating Expenses:	
Regulated Services	41,997,200
Total	74,832,800
Net Operating Profit (Loss):	
Regulated Services	7,214,700
Unregulated Services	-3,988,800
Total	3,225,900
Total Non-Operating Profit (Loss):	3,575,884
Non-Operating Revenue	3,575,884
Non-Operating Expenses	0
Total Excess Profit (Loss):	6,801,826
Total Regulated Inpatient Admissions:	1,315
Total Regulated Outpatient Visits:	3,391

[4] FY 2014 is the first year that Levindale was designated as an acute care hospital by CMS.

McCready Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	16,638,000	17,975,600	17,710,400
Unregulated Services	1,397,602	1,661,066	1,964,859
TOTAL	18,035,602	19,636,666	19,675,259
Net Patient Revenue (NPR):			
Regulated Services	13,303,900	13,914,617	14,280,227
Unregulated Services	863,487	923,548	1,051,180
TOTAL	14,167,387	14,838,165	15,331,407
Other Operating Revenue:			
Regulated Services	1,301,193	90,951	42,511
Unregulated Services	83,844	8,651	5,490
TOTAL	1,385,037	99,602	48,001
Net Operating Revenue (NOR)			
Regulated Services	14,605,093	14,005,568	14,322,738
Unregulated Services	947,331	932,199	1,056,670
Total	15,552,424	14,937,767	15,379,408
Total Operating Expenses:			
Regulated Services	12,257,596	14,303,837	13,816,498
Total	13,788,378	14,472,624	13,999,158
Net Operating Profit (Loss):			
Regulated Services	2,347,500	-298,269	506,240
Unregulated Services	-583,451	763,412	874,010
Total	1,764,049	465,143	1,380,250
Total Non-Operating Profit (Loss):	107,518	-35,298	1,880,685
Non-Operating Revenue	107,518	103,748	1,880,685
Non-Operating Expenses	0	139,046	0
Total Excess Profit (Loss):	1,871,567	429,845	3,260,935
Total Regulated Inpatient Admissions:	321	297	399
Total Regulated Outpatient Visits:	13,413	13,299	14,361
Readmission Charges:	610,519	880,560	
Risk Adjusted Readmission Percent:	11.14%	13.27%	
Potentially Preventable Conditions (PPC) Costs	0	0	
Risk Adjusted PPC Rate:	0.00	0.00	
Potentially Avoidable Utilization Costs:	1,781,550	2,357,978	

MedStar Franklin Square

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	486,467,000	469,792,200	477,082,000
Unregulated Services	192,175,314	149,321,525	127,868,522
TOTAL	678,642,314	619,113,725	604,950,522
Net Patient Revenue (NPR):			
Regulated Services	407,447,444	385,021,682	391,379,153
Unregulated Services	70,000,653	55,271,201	50,326,959
TOTAL	477,448,097	440,292,883	441,706,112
Other Operating Revenue:			
Regulated Services	6,794,480	4,721,924	3,363,126
Unregulated Services	6,316,130	5,404,183	4,553,768
TOTAL	13,110,610	10,126,107	7,916,894
Net Operating Revenue (NOR)			
Regulated Services	414,241,924	389,743,606	394,742,279
Unregulated Services	76,316,783	60,675,384	54,880,727
Total	490,558,707	450,418,990	449,623,006
Total Operating Expenses:			
Regulated Services	373,444,124	363,168,650	363,245,385
Total	469,241,214	450,358,826	436,640,459
Net Operating Profit (Loss):			
Regulated Services	40,797,801	26,574,956	31,496,894
Unregulated Services	-19,480,307	-26,514,792	-18,514,347
Total	21,317,494	60,164	12,982,547
Total Non-Operating Profit (Loss):	246,061	365,370	304,953
Non-Operating Revenue	246,061	365,370	304,953
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	21,563,555	425,534	13,287,500
Total Regulated Inpatient Admissions:	21,804	21,997	22,145
Total Regulated Outpatient Visits:	168,073	170,528	172,628
Readmission Charges:	55,138,662	49,266,677	
Risk Adjusted Readmission Percent:	13.97%	13.75%	
Potentially Preventable Conditions (PPC) Costs	9,643,067	11,211,987	
Risk Adjusted PPC Rate:	1.00	1.11	
Potentially Avoidable Utilization Costs:	91,907,129	89,871,664	

MedStar Good Samaritan

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	299,250,000	295,736,800	311,855,400
Unregulated Services	142,342,915	143,520,878	127,393,726
TOTAL	441,592,915	439,257,678	439,249,126
Net Patient Revenue (NPR):			
Regulated Services	242,965,630	239,029,241	251,566,429
Unregulated Services	49,688,130	49,676,077	51,726,988
TOTAL	292,653,760	288,705,318	303,293,417
Other Operating Revenue:			
Regulated Services	7,433,958	3,998,131	3,037,752
Unregulated Services	7,188,325	6,882,784	1,023,745
TOTAL	14,622,283	10,880,915	4,061,497
Net Operating Revenue (NOR)			
Regulated Services	250,399,588	243,027,372	254,604,181
Unregulated Services	56,876,455	56,558,861	52,750,733
Total	307,276,043	299,586,233	307,354,914
Total Operating Expenses:			
Regulated Services	224,965,932	230,253,466	232,260,097
Total	303,307,419	307,783,651	299,758,071
Net Operating Profit (Loss):			
Regulated Services	25,433,656	12,773,906	22,344,084
Unregulated Services	-21,465,032	-20,971,324	-14,747,241
Total	3,968,625	-8,197,418	7,596,843
Total Non-Operating Profit (Loss):	3,219	71,034	1,008,235
Non-Operating Revenue	43,284	56,644	1,013,557
Non-Operating Expenses	40,065	-14,390	5,322
Total Excess Profit (Loss):	3,971,844	-8,126,384	8,605,078
Total Regulated Inpatient Admissions:	11,759	13,416	14,948
Total Regulated Outpatient Visits:	90,430	88,921	84,859
Readmission Charges:	33,353,859	36,816,669	
Risk Adjusted Readmission Percent:	15.19%	15.29%	
Potentially Preventable Conditions (PPC) Costs	5,307,301	7,186,091	
Risk Adjusted PPC Rate:	0.83	1.16	
Potentially Avoidable Utilization Costs:	54,578,301	60,749,450	

MedStar Harbor Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	205,146,300	201,141,000	209,694,300
Unregulated Services	78,505,062	72,945,343	66,803,107
TOTAL	283,651,362	274,086,343	276,497,407
Net Patient Revenue (NPR):			
Regulated Services	171,046,194	165,007,143	166,004,244
Unregulated Services	25,319,070	25,598,351	21,464,485
TOTAL	196,365,264	190,605,494	187,468,729
Other Operating Revenue:			
Regulated Services	5,371,719	5,160,187	3,495,467
Unregulated Services	8,195,974	8,819,001	8,367,663
TOTAL	13,567,693	13,979,188	11,863,130
Net Operating Revenue (NOR)			
Regulated Services	176,417,913	170,167,330	169,499,711
Unregulated Services	33,515,044	34,417,352	29,832,148
Total	209,932,957	204,584,682	199,331,859
Total Operating Expenses:			
Regulated Services	146,516,583	157,878,796	166,965,434
Total	189,700,114	198,800,877	202,041,627
Net Operating Profit (Loss):			
Regulated Services	29,901,331	12,288,534	2,534,277
Unregulated Services	-9,668,488	-6,504,729	-5,244,045
Total	20,232,843	5,783,805	-2,709,768
Total Non-Operating Profit (Loss):	506,890	277,299	220,219
Non-Operating Revenue	506,890	198,723	220,219
Non-Operating Expenses	0	-78,576	0
Total Excess Profit (Loss):	20,739,733	6,061,104	-2,489,549
Total Regulated Inpatient Admissions:	7,624	8,581	10,096
Total Regulated Outpatient Visits:	66,579	67,279	62,867
Readmission Charges:	18,363,094	20,799,635	
Risk Adjusted Readmission Percent:	13.77%	14.40%	
Potentially Preventable Conditions (PPC) Costs	4,674,145	4,827,281	
Risk Adjusted PPC Rate:	1.09	1.06	
Potentially Avoidable Utilization Costs:	33,760,818	37,080,813	

MedStar Montgomery General

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	167,893,100	166,869,100	165,915,000
Unregulated Services	8,493,778	8,456,700	7,665,307
TOTAL	176,386,878	175,325,800	173,580,307
Net Patient Revenue (NPR):			
Regulated Services	141,046,268	140,038,336	139,632,555
Unregulated Services	4,590,335	4,357,068	3,286,403
TOTAL	145,636,603	144,395,405	142,918,959
Other Operating Revenue:			
Regulated Services	2,796,922	5,386,913	2,680,765
Unregulated Services	282,582	733,038	894,651
TOTAL	3,079,504	6,119,951	3,575,416
Net Operating Revenue (NOR)			
Regulated Services	143,843,190	145,425,249	142,313,320
Unregulated Services	4,872,917	5,090,107	4,181,054
Total	148,716,107	150,515,356	146,494,375
Total Operating Expenses:			
Regulated Services	128,893,109	128,574,908	124,575,881
Total	141,655,632	143,428,725	137,669,098
Net Operating Profit (Loss):			
Regulated Services	14,950,082	16,850,341	17,737,440
Unregulated Services	-7,889,606	-9,763,710	-8,912,163
Total	7,060,476	7,086,631	8,825,276
Total Non-Operating Profit (Loss):	15,370	175,895	179,353
Non-Operating Revenue	15,370	175,895	179,353
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	7,075,846	7,262,526	9,004,630
Total Regulated Inpatient Admissions:	8,230	8,615	9,247
Total Regulated Outpatient Visits:	74,747	72,298	67,026
Readmission Charges:	13,130,641	14,208,780	
Risk Adjusted Readmission Percent:	12.70%	12.91%	
Potentially Preventable Conditions (PPC) Costs	2,709,450	4,179,895	
Risk Adjusted PPC Rate:	1.26	1.52	
Potentially Avoidable Utilization Costs:	23,972,354	26,667,246	

MedStar Saint Mary's Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	157,936,000	154,603,000	151,897,000
Unregulated Services	12,443,429	11,584,466	10,086,460
TOTAL	170,379,429	166,187,466	161,983,460
Net Patient Revenue (NPR):			
Regulated Services	131,499,627	122,725,928	115,905,184
Unregulated Services	6,799,669	8,136,699	9,418,294
TOTAL	138,299,296	130,862,627	125,323,478
Other Operating Revenue:			
Regulated Services	2,960,850	252,484	4,778,880
Unregulated Services	1,745,067	2,025,953	1,180,088
TOTAL	4,705,917	2,278,437	5,958,967
Net Operating Revenue (NOR)			
Regulated Services	134,460,477	122,978,411	120,684,064
Unregulated Services	8,544,736	10,162,653	10,598,382
Total	143,005,213	133,141,064	131,282,445
Total Operating Expenses:			
Regulated Services	114,088,512	106,669,520	106,515,296
Total	131,503,457	122,895,946	121,640,602
Net Operating Profit (Loss):			
Regulated Services	20,371,965	16,308,891	14,168,767
Unregulated Services	-8,870,208	-6,063,773	-4,526,924
Total	11,501,757	10,245,118	9,641,843
Total Non-Operating Profit (Loss):	769,829	2,103,498	-1,535
Non-Operating Revenue	769,829	444,111	277,093
Non-Operating Expenses	0	-1,659,387	278,628
Total Excess Profit (Loss):	12,271,586	12,348,616	9,640,308
Total Regulated Inpatient Admissions:	6,681	7,477	7,581
Total Regulated Outpatient Visits:	67,665	68,692	66,876
Readmission Charges:	10,189,136	11,003,019	
Risk Adjusted Readmission Percent:	12.57%	13.55%	
Potentially Preventable Conditions (PPC) Costs	1,196,713	1,444,025	
Risk Adjusted PPC Rate:	0.82	0.96	
Potentially Avoidable Utilization Costs:	20,431,617	21,907,808	

MedStar Southern Maryland

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	261,812,300	259,132,417	241,038,800
Unregulated Services	10,051,455	15,399,200	31,423,033
TOTAL	271,863,755	274,531,617	272,461,833
Net Patient Revenue (NPR):			
Regulated Services	207,161,288	200,413,856	199,310,186
Unregulated Services	5,415,538	5,166,698	13,200,279
TOTAL	212,576,826	205,580,554	212,510,465
Other Operating Revenue:			
Regulated Services	402,847	114,400	269,077
Unregulated Services	882,941	959,834	628,599
TOTAL	1,285,788	1,074,234	897,676
Net Operating Revenue (NOR)			
Regulated Services	207,564,135	200,528,256	199,579,263
Unregulated Services	6,298,479	6,126,532	13,828,878
Total	213,862,614	206,654,788	213,408,141
Total Operating Expenses:			
Regulated Services	204,401,483	222,142,014	193,980,843
Total	219,466,790	234,305,692	217,937,158
Net Operating Profit (Loss):			
Regulated Services	3,162,651	-21,613,758	5,598,420
Unregulated Services	-8,766,828	-6,037,146	-10,127,437
Total	-5,604,177	-27,650,904	-4,529,017
Total Non-Operating Profit (Loss):	21,958	-104,289	-154,429
Non-Operating Revenue	21,958	0	-154,429
Non-Operating Expenses	0	104,289	0
Total Excess Profit (Loss):	-5,582,219	-21,613,758	-4,683,446
Total Regulated Inpatient Admissions:	13,178	16,421	15,272
Total Regulated Outpatient Visits:	73,008	49,127	64,776
Readmission Charges:	28,638,418	28,140,372	
Risk Adjusted Readmission Percent:	12.36%	12.57%	
Potentially Preventable Conditions (PPC) Costs	7,003,192	7,624,243	
Risk Adjusted PPC Rate:	1.25	1.46	
Potentially Avoidable Utilization Costs:	54,853,857	54,084,796	

MedStar Union Memorial

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	415,164,300	406,581,900	422,530,700
Unregulated Services	153,664,182	141,868,889	142,322,669
TOTAL	568,828,482	548,450,789	564,853,369
Net Patient Revenue (NPR):			
Regulated Services	343,104,896	325,853,133	339,127,630
Unregulated Services	52,362,138	51,680,296	48,461,245
TOTAL	395,467,034	377,533,429	387,588,875
Other Operating Revenue:			
Regulated Services	4,836,762	6,118,228	4,132,978
Unregulated Services	8,902,680	8,020,221	8,577,492
TOTAL	13,739,442	14,138,449	12,710,470
Net Operating Revenue (NOR)			
Regulated Services	347,941,658	331,971,361	343,260,608
Unregulated Services	61,264,818	59,700,517	57,038,737
Total	409,206,476	391,671,878	400,299,345
Total Operating Expenses:			
Regulated Services	301,629,439	311,635,984	311,843,852
Total	394,669,299	397,895,616	397,245,796
Net Operating Profit (Loss):			
Regulated Services	46,312,220	20,335,376	31,416,756
Unregulated Services	-31,775,042	-26,559,115	-28,363,207
Total	14,537,178	-6,223,738	3,053,549
Total Non-Operating Profit (Loss):	5,852,483	4,750,979	1,030,745
Non-Operating Revenue	5,852,483	4,750,979	1,030,745
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	20,389,661	-1,472,759	4,084,294
Total Regulated Inpatient Admissions:	12,811	14,044	14,914
Total Regulated Outpatient Visits:	110,467	110,887	100,138
Readmission Charges:	36,462,671	35,288,245	
Risk Adjusted Readmission Percent:	14.57%	15.01%	
Potentially Preventable Conditions (PPC) Costs	11,124,318	14,581,503	
Risk Adjusted PPC Rate:	1.09	1.45	
Potentially Avoidable Utilization Costs:	62,527,286	65,790,576	

Mercy Medical Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	489,187,300	470,759,600	459,265,700
Unregulated Services	749,899	627,139	683,968
TOTAL	489,937,199	471,386,739	459,949,668
Net Patient Revenue (NPR):			
Regulated Services	408,619,365	398,432,064	385,649,759
Unregulated Services	749,899	627,139	683,968
TOTAL	409,369,264	399,059,203	386,333,727
Other Operating Revenue:			
Regulated Services	8,959,900	3,404,900	8,682,300
Unregulated Services	14,885,430	14,337,643	13,322,987
TOTAL	23,845,330	17,742,543	22,005,287
Net Operating Revenue (NOR)			
Regulated Services	417,579,265	401,836,964	394,332,059
Unregulated Services	15,635,329	14,964,782	14,006,955
Total	433,214,594	416,801,746	408,339,014
Total Operating Expenses:			
Regulated Services	403,467,951	386,407,071	372,534,729
Total	426,907,582	413,737,170	399,668,121
Net Operating Profit (Loss):			
Regulated Services	14,111,314	15,429,893	21,797,330
Unregulated Services	-7,804,301	-12,365,317	-13,126,437
Total	6,307,013	3,064,576	8,670,893
Total Non-Operating Profit (Loss):	9,709,384	27,955,631	-22,986,000
Non-Operating Revenue	8,724,168	19,458,083	263,000
Non-Operating Expenses	-985,216	-8,497,548	23,249,000
Total Excess Profit (Loss):	16,016,399	31,020,207	-14,315,107
Total Regulated Inpatient Admissions:	15,231	16,473	16,740
Total Regulated Outpatient Visits:	185,353	189,379	201,117
Readmission Charges:	29,798,310	26,898,977	
Risk Adjusted Readmission Percent:	15.65%	14.74%	
Potentially Preventable Conditions (PPC) Costs	7,800,670	8,345,522	
Risk Adjusted PPC Rate:	1.01	1.16	
Potentially Avoidable Utilization Costs:	48,445,110	47,155,802	

Meritus Medical Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	305,141,600	301,350,700	295,465,200
Unregulated Services	59,470,600	56,210,900	56,964,400
TOTAL	364,612,200	357,561,600	352,429,600
Net Patient Revenue (NPR):			
Regulated Services	247,293,500	247,469,100	244,455,300
Unregulated Services	36,504,200	33,954,400	31,708,200
TOTAL	283,797,700	281,423,500	276,163,500
Other Operating Revenue:			
Regulated Services	4,178,200	7,830,700	7,051,500
Unregulated Services	8,868,100	7,696,600	2,896,900
TOTAL	13,046,300	15,527,300	9,948,400
Net Operating Revenue (NOR)			
Regulated Services	251,471,700	255,299,800	251,506,800
Unregulated Services	45,372,300	41,651,000	34,605,100
Total	296,844,000	296,950,800	286,111,900
Total Operating Expenses:			
Regulated Services	246,754,400	244,991,246	247,646,762
Total	292,347,100	285,886,372	283,953,400
Net Operating Profit (Loss):			
Regulated Services	4,717,300	10,308,554	3,860,038
Unregulated Services	-220,400	755,874	-1,701,538
Total	4,496,900	11,064,428	2,158,500
Total Non-Operating Profit (Loss):	14,486,000	-1,948,200	2,553,900
Non-Operating Revenue	14,486,000	9,342,900	2,553,900
Non-Operating Expenses	0	11,291,100	0
Total Excess Profit (Loss):	18,982,900	9,116,228	4,712,400
Total Regulated Inpatient Admissions:	16,542	15,846	15,558
Total Regulated Outpatient Visits:	106,662	107,718	111,239
Readmission Charges:	28,386,681	29,519,745	
Risk Adjusted Readmission Percent:	12.66%	11.60%	
Potentially Preventable Conditions (PPC) Costs	5,950,468	8,664,950	
Risk Adjusted PPC Rate:	0.96	1.46	
Potentially Avoidable Utilization Costs:	51,126,663	55,866,659	

Northwest Hospital Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	249,134,500	248,252,700	238,730,100
Unregulated Services	40,289,193	36,074,239	31,341,808
TOTAL	289,423,693	284,326,939	270,071,908
Net Patient Revenue (NPR):			
Regulated Services	198,880,687	197,370,392	193,159,085
Unregulated Services	16,322,685	16,188,598	12,355,386
TOTAL	215,203,372	213,558,990	205,514,471
Other Operating Revenue:			
Regulated Services	2,083,246	2,225,751	3,904,164
Unregulated Services	6,071,930	5,389,249	4,202,790
TOTAL	8,155,176	7,615,000	8,106,954
Net Operating Revenue (NOR)			
Regulated Services	200,963,933	199,596,143	197,063,249
Unregulated Services	22,394,615	21,577,847	16,558,176
Total	223,358,548	221,173,990	213,621,425
Total Operating Expenses:			
Regulated Services	177,499,465	179,749,164	178,234,237
Total	213,902,245	207,890,900	203,241,310
Net Operating Profit (Loss):			
Regulated Services	23,464,469	19,846,980	18,829,012
Unregulated Services	-14,008,165	-6,563,890	-8,448,897
Total	9,456,304	13,283,090	10,380,115
Total Non-Operating Profit (Loss):	16,161,910	10,330,900	1,315,681
Non-Operating Revenue	16,161,910	9,138,000	1,315,681
Non-Operating Expenses	0	-1,192,900	0
Total Excess Profit (Loss):	25,618,214	23,613,990	11,695,796
Total Regulated Inpatient Admissions:	12,403	14,013	13,666
Total Regulated Outpatient Visits:	85,655	85,347	83,313
Readmission Charges:	31,146,779	31,779,863	
Risk Adjusted Readmission Percent:	15.57%	15.69%	
Potentially Preventable Conditions (PPC) Costs	4,911,932	8,195,596	
Risk Adjusted PPC Rate:	1.06	1.78	
Potentially Avoidable Utilization Costs:	53,810,791	58,233,463	

Peninsula Regional Medical Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	416,388,900	412,641,500	414,765,500
Unregulated Services	65,260,800	65,444,500	62,011,400
TOTAL	481,649,700	478,086,000	476,776,900
Net Patient Revenue (NPR):			
Regulated Services	344,224,200	335,753,200	336,910,100
Unregulated Services	24,311,800	23,926,300	24,508,400
TOTAL	368,536,000	359,679,500	361,418,500
Other Operating Revenue:			
Regulated Services	4,808,700	5,401,400	1,238,700
Unregulated Services	2,542,800	1,063,700	1,151,100
TOTAL	7,351,500	6,465,100	2,389,800
Net Operating Revenue (NOR)			
Regulated Services	349,032,900	341,154,600	338,148,800
Unregulated Services	26,854,600	24,990,000	25,659,500
Total	375,887,500	366,144,600	363,808,300
Total Operating Expenses:			
Regulated Services	312,613,046	315,285,076	309,515,853
Total	368,196,500	369,279,600	357,522,300
Net Operating Profit (Loss):			
Regulated Services	36,419,854	25,869,524	28,632,947
Unregulated Services	-28,728,854	-29,004,524	-22,346,947
Total	7,691,000	-3,135,000	6,286,000
Total Non-Operating Profit (Loss):	21,729,000	13,854,000	9,551,000
Non-Operating Revenue	21,729,000	13,854,000	9,603,000
Non-Operating Expenses	0	0	52,000
Total Excess Profit (Loss):	29,420,000	10,719,000	15,837,000
Total Regulated Inpatient Admissions:	17,344	17,915	19,139
Total Regulated Outpatient Visits:	120,004	118,568	118,097
Readmission Charges:	32,271,933	30,595,588	
Risk Adjusted Readmission Percent:	12.36%	10.98%	
Potentially Preventable Conditions (PPC) Costs	11,250,126	12,821,039	
Risk Adjusted PPC Rate:	1.29	1.43	
Potentially Avoidable Utilization Costs:	61,274,484	61,470,269	

Prince Georges' Hospital Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	267,282,400	249,192,555	255,903,800
Unregulated Services	19,068,307	16,344,218	16,268,731
TOTAL	286,350,707	265,536,772	272,172,531
Net Patient Revenue (NPR):			
Regulated Services	218,330,120	205,002,819	204,531,176
Unregulated Services	7,067,837	6,571,695	6,303,810
TOTAL	225,397,957	211,574,515	210,834,986
Other Operating Revenue:			
Regulated Services	3,683,713	3,652,361	1,273,509
Unregulated Services	1,476,428	1,260,997	997,687
TOTAL	5,160,141	4,913,358	2,271,197
Net Operating Revenue (NOR)			
Regulated Services	222,013,833	208,655,180	205,804,685
Unregulated Services	8,544,265	7,832,692	7,301,497
Total	230,558,098	216,487,873	213,106,183
Total Operating Expenses:			
Regulated Services	217,477,104	211,129,768	203,825,149
Total	249,691,862	237,801,774	227,988,386
Net Operating Profit (Loss):			
Regulated Services	4,536,729	-2,474,588	1,979,536
Unregulated Services	-23,670,492	-18,839,314	-16,861,740
Total	-19,133,763	-21,313,902	-14,882,204
Total Non-Operating Profit (Loss):	22,326,150	22,342,000	22,252,141
Non-Operating Revenue	22,326,150	22,342,000	22,252,141
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	3,192,390	1,028,098	7,369,937
Total Regulated Inpatient Admissions:	11,437	10,400	11,365
Total Regulated Outpatient Visits:	49,899	54,507	54,868
Readmission Charges:	20,709,894	20,745,116	
Risk Adjusted Readmission Percent:	11.23%	11.30%	
Potentially Preventable Conditions (PPC) Costs	4,193,046	5,840,172	
Risk Adjusted PPC Rate:	0.86	1.13	
Potentially Avoidable Utilization Costs:	41,964,827	42,274,789	

Queen Anne's Emergency Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	5,190,800	4,999,900	5,262,800
Unregulated Services	0	0	0
TOTAL	5,190,800	4,999,900	5,262,800
Net Patient Revenue (NPR):			
Regulated Services	4,257,207	4,038,910	4,141,820
Unregulated Services	0	0	0
TOTAL	4,257,207	4,038,910	4,141,820
Other Operating Revenue:			
Regulated Services	9,569	15,386	-1
Unregulated Services	0	0	1
TOTAL	9,569	15,386	0
Net Operating Revenue (NOR)			
Regulated Services	4,266,776	4,054,296	4,141,819
Unregulated Services	0	0	1
Total	4,266,776	4,054,296	4,141,820
Total Operating Expenses:			
Regulated Services	7,584,616	7,562,784	5,951,191
Total	7,584,616	7,562,784	5,951,191
Net Operating Profit (Loss):			
Regulated Services	-3,317,840	-3,508,488	-1,809,372
Unregulated Services	0	0	1
Total	-3,317,840	-3,508,488	-1,809,371
Total Non-Operating Profit (Loss):	-29,398	50,254	-116,436
Non-Operating Revenue	-29,398	50,254	-116,436
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-3,347,238	-3,458,234	-1,925,807
Total Regulated Inpatient Admissions:	0	0	0
Total Regulated Outpatient Visits:	14,793	14,434	14,713

Saint Agnes Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	410,191,100	404,669,900	401,564,200
Unregulated Services	164,764,875	166,822,313	158,452,693
TOTAL	574,955,975	571,492,213	560,016,893
Net Patient Revenue (NPR):			
Regulated Services	336,783,777	331,731,681	330,910,826
Unregulated Services	69,199,726	69,671,974	69,184,299
TOTAL	405,983,504	401,403,655	400,095,125
Other Operating Revenue:			
Regulated Services	5,698,599	6,619,006	4,476,674
Unregulated Services	5,273,683	5,465,872	5,432,666
TOTAL	10,972,282	12,084,878	9,909,340
Net Operating Revenue (NOR)			
Regulated Services	342,482,376	338,350,687	335,387,500
Unregulated Services	74,473,409	75,137,846	74,616,966
Total	416,955,786	413,488,533	410,004,465
Total Operating Expenses:			
Regulated Services	289,084,013	282,897,718	286,983,653
Total	393,019,853	387,262,188	388,515,810
Net Operating Profit (Loss):			
Regulated Services	53,398,364	55,452,969	48,403,847
Unregulated Services	-29,462,430	-29,226,624	-26,915,191
Total	23,935,933	26,226,345	21,488,655
Total Non-Operating Profit (Loss):	20,935,447	15,657,000	22,026,368
Non-Operating Revenue	22,133,540	15,619,000	478,886
Non-Operating Expenses	1,198,093	-38,000	-21,547,482
Total Excess Profit (Loss):	44,871,382	41,883,345	43,515,023
Total Regulated Inpatient Admissions:	17,541	17,907	19,122
Total Regulated Outpatient Visits:	147,167	142,392	138,372
Readmission Charges:	42,762,725	40,775,025	
Risk Adjusted Readmission Percent:	14.61%	14.28%	
Potentially Preventable Conditions (PPC) Costs	7,664,552	10,793,024	
Risk Adjusted PPC Rate:	1.03	1.43	
Potentially Avoidable Utilization Costs:	74,655,695	75,344,635	

Shady Grove Adventist Hospital

FISCAL YEAR ENDING	December 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	383,323,300	375,189,800	348,706,200
Unregulated Services	21,122,086	27,614,020	30,434,434
TOTAL	404,445,386	402,803,820	379,140,634
Net Patient Revenue (NPR):			
Regulated Services	322,939,414	306,717,029	294,975,318
Unregulated Services	11,062,723	13,372,763	14,983,447
TOTAL	334,002,137	320,089,792	309,958,765
Other Operating Revenue:			
Regulated Services	3,045,364	5,247,337	2,524,169
Unregulated Services	6,356,051	5,820,855	6,341,040
TOTAL	9,401,415	11,068,192	8,865,209
Net Operating Revenue (NOR)			
Regulated Services	325,984,778	311,964,366	297,499,487
Unregulated Services	17,418,774	19,193,618	21,324,487
Total	343,403,552	331,157,984	318,823,974
Total Operating Expenses:			
Regulated Services	294,301,624	283,029,117	277,340,979
Total	326,254,601	315,633,624	310,920,356
Net Operating Profit (Loss):			
Regulated Services	31,683,154	28,935,249	20,158,508
Unregulated Services	-14,534,203	-13,410,889	-12,254,890
Total	17,148,951	15,524,360	7,903,618
Total Non-Operating Profit (Loss):	1,178,041	-260,667	1,005,006
Non-Operating Revenue	1,178,041	-260,667	1,802,328
Non-Operating Expenses	0	0	797,322
Total Excess Profit (Loss):	18,326,992	15,263,693	8,908,624
Total Regulated Inpatient Admissions:	19,533	20,321	21,112
Total Regulated Outpatient Visits:	95,364	97,692	91,754
Readmission Charges:	27,075,280	28,716,222	
Risk Adjusted Readmission Percent:	11.38%	11.95%	
Potentially Preventable Conditions (PPC) Costs	6,401,554	5,832,026	
Risk Adjusted PPC Rate:	0.81	0.79	
Potentially Avoidable Utilization Costs:	48,070,854	43,249,842	

Sinai Hospital of Baltimore

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	699,430,000	684,516,800	676,602,700
Unregulated Services	193,082,993	169,421,934	153,761,069
TOTAL	892,512,993	853,938,734	830,363,769
Net Patient Revenue (NPR):			
Regulated Services	565,895,246	564,285,587	565,251,457
Unregulated Services	83,756,627	81,351,241	72,810,960
TOTAL	649,651,873	645,636,828	638,062,417
Other Operating Revenue:			
Regulated Services	11,819,850	16,233,000	6,501,576
Unregulated Services	41,560,500	34,075,711	38,199,150
TOTAL	53,380,350	50,308,711	44,700,726
Net Operating Revenue (NOR)			
Regulated Services	577,715,096	580,518,587	571,753,033
Unregulated Services	125,317,127	115,426,952	111,010,110
Total	703,032,223	695,945,539	682,763,143
Total Operating Expenses:			
Regulated Services	517,159,092	530,048,218	525,697,277
Total	675,091,241	680,645,621	668,599,780
Net Operating Profit (Loss):			
Regulated Services	60,556,006	50,470,369	46,055,756
Unregulated Services	-32,615,013	-35,170,451	-31,892,393
Total	27,940,993	15,299,918	14,163,363
Total Non-Operating Profit (Loss):	29,800,000	18,967,000	8,966,054
Non-Operating Revenue	29,800,000	18,967,000	8,966,054
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	57,740,993	34,266,918	23,129,417
Total Regulated Inpatient Admissions:	24,549	25,871	27,229
Total Regulated Outpatient Visits:	183,290	168,467	165,707
Readmission Charges:	57,482,479	57,115,974	
Risk Adjusted Readmission Percent:	14.97%	14.43%	
Potentially Preventable Conditions (PPC) Costs	14,774,950	20,703,914	
Risk Adjusted PPC Rate:	0.97	1.47	
Potentially Avoidable Utilization Costs:	89,495,796	94,620,833	

Suburban Hospital

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	289,286,600	280,578,500	272,892,400
Unregulated Services	9,632,810	10,147,116	10,349,192
TOTAL	298,919,410	290,725,616	283,241,592
Net Patient Revenue (NPR):			
Regulated Services	239,648,239	232,362,800	229,323,220
Unregulated Services	3,624,514	3,093,016	7,363,073
TOTAL	243,272,753	235,455,816	236,686,293
Other Operating Revenue:			
Regulated Services	2,720,835	7,003,940	4,740,818
Unregulated Services	18,648,960	42,394,260	11,768,869
TOTAL	21,369,795	49,398,200	16,509,687
Net Operating Revenue (NOR)			
Regulated Services	242,369,074	239,366,740	234,064,038
Unregulated Services	22,273,474	45,487,276	19,131,942
Total	264,642,548	284,854,016	253,195,980
Total Operating Expenses:			
Regulated Services	225,204,531	218,871,188	216,882,253
Total	262,016,800	251,081,646	239,149,257
Net Operating Profit (Loss):			
Regulated Services	17,164,544	20,495,552	17,181,785
Unregulated Services	-14,538,791	13,276,817	-3,135,062
Total	2,625,753	33,772,370	14,046,723
Total Non-Operating Profit (Loss):	13,775,934	4,362,488	-2,603,825
Non-Operating Revenue	14,727,120	4,362,488	-2,603,825
Non-Operating Expenses	951,186	0	0
Total Excess Profit (Loss):	16,401,687	38,134,858	11,442,898
Total Regulated Inpatient Admissions:	13,183	13,210	14,172
Total Regulated Outpatient Visits:	76,845	79,694	78,221
Readmission Charges:	23,638,589	20,834,542	
Risk Adjusted Readmission Percent:	11.83%	11.63%	
Potentially Preventable Conditions (PPC) Costs	8,021,007	10,400,132	
Risk Adjusted PPC Rate:	1.27	1.58	
Potentially Avoidable Utilization Costs:	40,831,795	41,607,976	

UM Baltimore Washington

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	393,181,900	376,812,800	381,065,300
Unregulated Services	28,963,224	10,944,461	11,077,953
TOTAL	422,145,124	387,757,261	392,143,253
Net Patient Revenue (NPR):			
Regulated Services	320,033,920	308,070,323	312,825,359
Unregulated Services	11,367,399	10,944,461	11,077,953
TOTAL	331,401,319	319,014,784	323,903,313
Other Operating Revenue:			
Regulated Services	2,304,241	1,904,465	2,569,890
Unregulated Services	1,694,936	1,670,068	1,558,022
TOTAL	3,999,177	3,574,533	4,127,912
Net Operating Revenue (NOR)			
Regulated Services	322,338,161	309,974,788	315,395,249
Unregulated Services	13,062,335	12,614,529	12,635,976
Total	335,400,496	322,589,317	328,031,225
Total Operating Expenses:			
Regulated Services	296,252,216	307,055,161	301,328,290
Total	319,029,811	326,994,589	313,491,003
Net Operating Profit (Loss):			
Regulated Services	26,085,945	2,919,627	14,066,959
Unregulated Services	-9,715,260	-7,324,899	473,264
Total	16,370,685	-4,405,272	14,540,222
Total Non-Operating Profit (Loss):	3,103,362	24,629	-3,288,000
Non-Operating Revenue	6,430,980	4,424,231	1,577,000
Non-Operating Expenses	3,327,618	4,399,602	4,865,000
Total Excess Profit (Loss):	19,474,047	-4,380,643	11,252,222
Total Regulated Inpatient Admissions:	17,827	18,921	18,543
Total Regulated Outpatient Visits:	133,823	134,995	138,344
Readmission Charges:	45,706,674	40,162,146	
Risk Adjusted Readmission Percent:	14.93%	15.03%	
Potentially Preventable Conditions (PPC) Costs	9,343,776	10,417,975	
Risk Adjusted PPC Rate:	1.01	1.27	
Potentially Avoidable Utilization Costs:	77,870,191	73,245,926	

UM Charles Regional Medical Center

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	144,785,724	137,003,900	126,393,900
Unregulated Services	790,489	999,343	425,147
TOTAL	145,576,213	138,003,243	126,819,047
Net Patient Revenue (NPR):			
Regulated Services	118,662,627	112,746,501	103,830,122
Unregulated Services	579,067	842,746	215,805
TOTAL	119,241,694	113,589,247	104,045,927
Other Operating Revenue:			
Regulated Services	28,963	-156,758	-282,149
Unregulated Services	481,289	483,220	474,202
TOTAL	510,252	326,462	192,054
Net Operating Revenue (NOR)			
Regulated Services	118,691,590	112,589,742	103,547,973
Unregulated Services	1,060,356	1,325,966	690,007
Total	119,751,946	113,915,709	104,237,981
Total Operating Expenses:			
Regulated Services	105,796,706	100,889,258	94,890,378
Total	108,754,924	103,915,537	96,010,018
Net Operating Profit (Loss):			
Regulated Services	12,894,884	11,700,484	8,657,595
Unregulated Services	-1,897,862	-1,700,312	-429,633
Total	10,997,022	10,000,172	8,227,962
Total Non-Operating Profit (Loss):	-828,000	-5,266,000	-8,884,000
Non-Operating Revenue	-1,009,000	-5,266,000	-8,884,000
Non-Operating Expenses	-181,000	0	0
Total Excess Profit (Loss):	10,169,022	4,734,172	-656,038
Total Regulated Inpatient Admissions:	7,554	7,717	7,083
Total Regulated Outpatient Visits:	71,016	55,414	56,821

Readmission Charges:	13,889,328	15,328,045
Risk Adjusted Readmission Percent:	12.89%	13.01%
Potentially Preventable Conditions (PPC) Costs	1,300,292	2,626,956
Risk Adjusted PPC Rate:	0.80	1.23
Potentially Avoidable Utilization Costs:	26,418,723	28,229,604

UM Harford Memorial Hospital

FISCAL YEAR ENDING	June 2014[5]	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	53,719,100	103,499,300	104,451,400
Unregulated Services	60,300	130,700	163,300
TOTAL	53,779,400	103,630,000	104,614,700
Net Patient Revenue (NPR):			
Regulated Services	44,777,400	80,749,039	82,984,005
Unregulated Services	44,700	61,300	104,000
TOTAL	44,822,100	80,810,339	83,088,005
Other Operating Revenue:			
Regulated Services	656,400	2,452,600	1,050,423
Unregulated Services	175,100	479,400	2,361,577
TOTAL	831,500	2,932,000	3,412,000
Net Operating Revenue (NOR)			
Regulated Services	45,433,800	83,201,639	84,034,428
Unregulated Services	219,800	540,700	2,465,577
Total	45,653,600	83,742,339	86,500,005
Total Operating Expenses:			
Regulated Services	39,181,300	77,131,271	80,495,251
Total	40,864,200	79,558,000	83,528,951
Net Operating Profit (Loss):			
Regulated Services	6,252,500	6,070,368	3,539,177
Unregulated Services	-1,463,100	-1,886,029	-568,123
Total	4,789,400	4,184,339	2,971,054
Total Non-Operating Profit (Loss):	1,915,300	7,340,000	5,297,000
Non-Operating Revenue	1,915,300	7,340,000	5,297,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	6,704,700	11,524,339	8,268,054
Total Regulated Inpatient Admissions:	2,351	4,727	5,132
Total Regulated Outpatient Visits:	44,589	47,081	43,330
Readmission Charges:	12,066,425	11,569,256	
Risk Adjusted Readmission Percent:	12.51%	12.26%	
Potentially Preventable Conditions (PPC) Costs	1,533,980	1,862,884	
Risk Adjusted PPC Rate:	1.16	1.47	
Potentially Avoidable Utilization Costs:	21,069,537	20,207,171	

[5] UM Harford Memorial changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of six (6) months.

UM Midtown

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	222,427,600	216,173,800	185,438,390
Unregulated Services	15,808,226	19,029,350	8,054,159
TOTAL	238,235,826	235,203,150	193,492,549
Net Patient Revenue (NPR):			
Regulated Services	174,389,612	177,185,337	154,041,944
Unregulated Services	5,994,896	6,168,253	8,008,771
TOTAL	180,384,509	183,353,590	162,050,715
Other Operating Revenue:			
Regulated Services	1,163,270	270,527	865,829
Unregulated Services	998,502	1,212,224	1,157,473
TOTAL	2,161,772	1,482,751	2,023,301
Net Operating Revenue (NOR)			
Regulated Services	175,552,882	177,455,864	154,907,773
Unregulated Services	6,993,398	7,380,478	9,166,243
Total	182,546,280	184,836,341	164,074,016
Total Operating Expenses:			
Regulated Services	152,556,172	159,502,922	144,339,647
Total	178,869,079	188,088,728	168,209,026
Net Operating Profit (Loss):			
Regulated Services	22,996,711	17,952,942	10,568,126
Unregulated Services	-19,319,509	-21,205,328	-14,703,136
Total	3,677,202	-3,252,386	-4,135,010
Total Non-Operating Profit (Loss):	-599,000	-432,000	-678,000
Non-Operating Revenue	-599,000	-432,000	100,000
Non-Operating Expenses	0	0	778,000
Total Excess Profit (Loss):	3,078,202	-3,684,386	-4,813,010
Total Regulated Inpatient Admissions:	6,178	7,527	8,870
Total Regulated Outpatient Visits:	88,554	66,762	52,874
Readmission Charges:	26,934,870	27,938,051	
Risk Adjusted Readmission Percent:	17.53%	16.94%	
Potentially Preventable Conditions (PPC) Costs	2,231,434	3,787,589	
Risk Adjusted PPC Rate:	0.99	1.53	
Potentially Avoidable Utilization Costs:	36,430,004	39,977,045	

UM Rehabilitation & Orthopedic Institute

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	118,262,200	115,227,400	117,995,400
Unregulated Services	1,205,991	1,438,975	1,667,820
TOTAL	119,468,191	116,666,375	119,663,220
Net Patient Revenue (NPR):			
Regulated Services	98,687,200	97,022,400	99,715,400
Unregulated Services	611,991	806,975	916,820
TOTAL	99,299,191	97,829,375	100,632,220
Other Operating Revenue:			
Regulated Services	2,099,610	705,340	1,040,606
Unregulated Services	1,870,812	1,810,147	1,841,976
TOTAL	3,970,422	2,515,487	2,882,582
Net Operating Revenue (NOR)			
Regulated Services	100,786,810	97,727,740	100,756,006
Unregulated Services	2,482,803	2,617,121	2,758,796
Total	103,269,613	100,344,862	103,514,802
Total Operating Expenses:			
Regulated Services	99,422,003	98,425,900	95,494,655
Total	102,736,500	101,635,160	98,824,910
Net Operating Profit (Loss):			
Regulated Services	1,364,808	-698,160	5,261,351
Unregulated Services	-831,695	-592,139	-571,459
Total	533,113	-1,290,298	4,689,892
Total Non-Operating Profit (Loss):	1,269,000	905,000	-317,000
Non-Operating Revenue	1,269,000	905,000	-317,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	1,802,113	-385,298	4,372,892
Total Regulated Inpatient Admissions:	3,602	3,662	3,465
Total Regulated Outpatient Visits:	34,302	35,399	36,125
Readmission Charges:	5,350,299	6,222,857	
Risk Adjusted Readmission Percent:	12.22%	13.23%	
Potentially Preventable Conditions (PPC) Costs	1,367,772	1,824,710	
Risk Adjusted PPC Rate:	1.01	1.30	
Potentially Avoidable Utilization Costs:	6,718,071	8,047,567	

UM Saint Joseph

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	362,415,700	337,661,500	354,785,600
Unregulated Services	3,646,000	50,839,541	48,931,087
TOTAL	366,061,700	388,501,041	403,716,687
Net Patient Revenue (NPR):			
Regulated Services	295,642,876	251,556,991	286,710,810
Unregulated Services	3,416,124	24,022,541	23,504,013
TOTAL	299,059,000	275,579,532	310,214,823
Other Operating Revenue:			
Regulated Services	386,513	135,501	389,513
Unregulated Services	2,769,487	8,677,499	5,934,776
TOTAL	3,156,000	8,813,000	6,324,288
Net Operating Revenue (NOR)			
Regulated Services	296,029,390	251,692,492	287,100,323
Unregulated Services	6,185,610	32,700,040	29,438,788
Total	302,215,000	284,392,532	316,539,111
Total Operating Expenses:			
Regulated Services	288,320,773	284,063,416	286,684,281
Total	310,933,000	350,245,000	344,709,199
Net Operating Profit (Loss):			
Regulated Services	7,708,617	-32,370,924	416,042
Unregulated Services	-16,426,617	-33,481,543	-28,586,130
Total	-8,718,000	-65,852,468	-28,170,088
Total Non-Operating Profit (Loss):	-5,413,000	-6,660,000	3,763,186
Non-Operating Revenue	1,897,000	5,113,000	3,763,182
Non-Operating Expenses	7,310,000	11,773,000	-4
Total Excess Profit (Loss):	-14,131,000	-72,512,468	-24,406,902
Total Regulated Inpatient Admissions:	15,747	15,176	16,217
Total Regulated Outpatient Visits:	89,366	87,511	92,717
Readmission Charges:	22,275,798	23,781,364	
Risk Adjusted Readmission Percent:	12.30%	12.74%	
Potentially Preventable Conditions (PPC) Costs	7,175,579	11,396,757	
Risk Adjusted PPC Rate:	1.03	1.70	
Potentially Avoidable Utilization Costs:	39,525,607	45,000,037	

UM Shore Medical Chestertown

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	64,508,977	62,791,800	65,051,700
Unregulated Services	3,555,824	3,590,997	3,579,369
TOTAL	68,064,801	66,382,797	68,631,069
Net Patient Revenue (NPR):			
Regulated Services	49,270,622	48,143,539	49,528,431
Unregulated Services	3,379,824	3,231,997	2,157,309
TOTAL	52,650,446	51,375,536	51,685,740
Other Operating Revenue:			
Regulated Services	53,666	80,723	204,497
Unregulated Services	230,078	223,432	251,867
TOTAL	283,744	304,155	456,364
Net Operating Revenue (NOR)			
Regulated Services	49,324,288	48,224,262	49,732,928
Unregulated Services	3,609,902	3,455,429	2,409,176
Total	52,934,190	51,679,691	52,142,104
Total Operating Expenses:			
Regulated Services	40,990,213	46,820,546	50,318,541
Total	47,353,897	51,865,507	54,293,956
Net Operating Profit (Loss):			
Regulated Services	8,334,074	1,403,716	-585,613
Unregulated Services	-2,753,782	-1,589,533	-1,566,239
Total	5,580,293	-185,817	-2,151,852
Total Non-Operating Profit (Loss):	969,715	1,251,802	204,000
Non-Operating Revenue	1,041,405	1,251,802	602,016
Non-Operating Expenses	71,690	0	398,016
Total Excess Profit (Loss):	6,550,008	1,065,985	-1,947,852
Total Regulated Inpatient Admissions:	1,886	2,217	2,666
Total Regulated Outpatient Visits:	20,771	21,256	20,719
Readmission Charges:	5,346,104	5,751,989	
Risk Adjusted Readmission Percent:	13.79%	15.11%	
Potentially Preventable Conditions (PPC) Costs	499,904	1,268,429	
Risk Adjusted PPC Rate:	0.49	1.22	
Potentially Avoidable Utilization Costs:	10,843,377	12,317,063	

UM Shore Medical Dorchester

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	58,994,300	59,897,900	59,359,900
Unregulated Services	3,348,901	3,250,913	2,472,867
TOTAL	62,343,201	63,148,813	61,832,767
Net Patient Revenue (NPR):			
Regulated Services	44,745,961	46,893,694	47,614,371
Unregulated Services	950,026	1,296,834	734,338
TOTAL	45,695,987	48,190,528	48,348,709
Other Operating Revenue:			
Regulated Services	144,703	113,804	222,340
Unregulated Services	269,579	279,429	262,525
TOTAL	414,282	393,233	484,865
Net Operating Revenue (NOR)			
Regulated Services	44,890,664	47,007,498	47,836,711
Unregulated Services	1,219,605	1,576,264	996,863
Total	46,110,269	48,583,761	48,833,574
Total Operating Expenses:			
Regulated Services	36,608,786	38,660,406	40,439,854
Total	39,673,868	42,329,887	43,070,521
Net Operating Profit (Loss):			
Regulated Services	8,281,878	8,347,091	7,396,857
Unregulated Services	-1,845,477	-2,093,218	-1,633,805
Total	6,436,401	6,253,874	5,763,053
Total Non-Operating Profit (Loss):	-211,918	376,979	-186,965
Non-Operating Revenue	-211,918	376,979	-186,965
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	6,224,482	6,630,853	5,576,088
Total Regulated Inpatient Admissions:	2,408	2,611	2,844
Total Regulated Outpatient Visits:	23,248	26,416	24,509
Readmission Charges:	5,737,310	5,616,657	
Risk Adjusted Readmission Percent:	12.19%	11.75%	
Potentially Preventable Conditions (PPC) Costs	750,728	440,210	
Risk Adjusted PPC Rate:	1.27	0.97	
Potentially Avoidable Utilization Costs:	13,162,850	11,621,512	

UM Shore Medical Easton

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	187,483,400	186,358,600	184,647,500
Unregulated Services	43,572,553	39,880,874	37,070,671
TOTAL	231,055,953	226,239,474	221,718,171
Net Patient Revenue (NPR):			
Regulated Services	152,823,340	149,505,473	152,889,603
Unregulated Services	14,648,824	14,312,219	13,326,855
TOTAL	167,472,165	163,817,692	166,216,458
Other Operating Revenue:			
Regulated Services	814,178	918,482	3,652,293
Unregulated Services	1,841,348	1,650,793	934,678
TOTAL	2,655,526	2,569,275	4,586,971
Net Operating Revenue (NOR)			
Regulated Services	153,637,519	150,423,955	156,541,896
Unregulated Services	16,490,172	15,963,011	14,261,533
Total	170,127,691	166,386,967	170,803,429
Total Operating Expenses:			
Regulated Services	140,191,581	137,324,774	141,357,659
Total	160,828,827	156,018,117	155,789,668
Net Operating Profit (Loss):			
Regulated Services	13,445,938	13,099,182	15,184,237
Unregulated Services	-4,147,074	-2,730,332	-170,476
Total	9,298,864	10,368,850	15,013,761
Total Non-Operating Profit (Loss):	7,882,051	4,002,174	-1,952,423
Non-Operating Revenue	7,882,051	4,002,174	-1,952,423
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	17,180,916	14,371,024	13,061,338
Total Regulated Inpatient Admissions:	7,920	8,074	8,313
Total Regulated Outpatient Visits:	42,620	48,025	51,873
Readmission Charges:	13,108,829	12,141,164	
Risk Adjusted Readmission Percent:	12.64%	11.21%	
Potentially Preventable Conditions (PPC) Costs	2,207,562	2,544,508	
Risk Adjusted PPC Rate:	1.04	1.10	
Potentially Avoidable Utilization Costs:	26,124,017	25,055,040	

UM Upper Chesapeake

FISCAL YEAR ENDING	June 2014[6]	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	157,472,100	290,000,800	283,588,000
Unregulated Services	117,500	226,600	310,400
TOTAL	157,589,600	290,227,400	283,898,400
Net Patient Revenue (NPR):			
Regulated Services	138,670,800	241,546,300	237,245,612
Unregulated Services	84,900	121,000	205,200
TOTAL	138,755,700	241,667,300	237,450,812
Other Operating Revenue:			
Regulated Services	1,337,000	2,938,400	1,355,018
Unregulated Services	1,275,599	2,642,600	6,192,982
TOTAL	2,612,599	5,581,000	7,548,000
Net Operating Revenue (NOR)			
Regulated Services	140,007,800	244,484,700	238,600,630
Unregulated Services	1,360,499	2,763,600	6,398,182
Total	141,368,299	247,248,300	244,998,812
Total Operating Expenses:			
Regulated Services	116,409,100	220,046,741	217,111,969
Total	122,009,400	228,970,300	225,852,000
Net Operating Profit (Loss):			
Regulated Services	23,598,700	24,437,959	21,488,661
Unregulated Services	-4,239,800	-6,159,959	-2,341,849
Total	19,358,900	18,278,000	19,146,812
Total Non-Operating Profit (Loss):	187,500	4,122,000	-3,602,000
Non-Operating Revenue	187,500	4,122,000	471,000
Non-Operating Expenses	0	0	4,073,000
Total Excess Profit (Loss):	19,546,400	22,400,000	15,544,812
Total Regulated Inpatient Admissions:	5,940	12,589	12,968
Total Regulated Outpatient Visits:	67,110	130,608	123,564
Readmission Charges:	25,243,447	23,360,469	
Risk Adjusted Readmission Percent:	12.77%	12.46%	
Potentially Preventable Conditions (PPC) Costs	4,387,889	6,498,675	
Risk Adjusted PPC Rate:	0.94	1.38	
Potentially Avoidable Utilization Costs:	44,639,054	43,097,036	

[6] UM Upper Chesapeake changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.

Union Hospital of Cecil County

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	157,913,800	153,372,900	148,428,400
Unregulated Services	31,936,900	35,956,700	36,898,300
TOTAL	189,850,700	189,329,600	185,326,700
Net Patient Revenue (NPR):			
Regulated Services	130,347,100	125,947,900	121,323,300
Unregulated Services	14,803,200	15,230,700	15,504,200
TOTAL	145,150,300	141,178,600	136,827,500
Other Operating Revenue:			
Regulated Services	2,557,500	2,787,800	618,900
Unregulated Services	2,080,699	2,087,100	1,916,900
TOTAL	4,638,199	4,874,900	2,535,800
Net Operating Revenue (NOR)			
Regulated Services	132,904,600	128,735,700	121,942,200
Unregulated Services	16,883,899	17,317,800	17,421,100
Total	149,788,499	146,053,500	139,363,300
Total Operating Expenses:			
Regulated Services	117,995,300	112,982,000	106,988,700
Total	146,416,200	140,941,500	134,374,600
Net Operating Profit (Loss):			
Regulated Services	14,909,300	15,753,700	14,953,500
Unregulated Services	-11,537,000	-10,641,700	-9,964,800
Total	3,372,300	5,112,000	4,988,700
Total Non-Operating Profit (Loss):	7,438,200	4,169,500	-732,300
Non-Operating Revenue	7,725,300	4,771,900	-344,500
Non-Operating Expenses	287,100	602,400	387,800
Total Excess Profit (Loss):	10,810,500	9,281,500	4,256,400
Total Regulated Inpatient Admissions:	5,045	5,750	6,347
Total Regulated Outpatient Visits:	44,457	47,563	50,709
Readmission Charges:	10,347,606	10,063,684	
Risk Adjusted Readmission Percent:	10.60%	11.24%	
Potentially Preventable Conditions (PPC) Costs	2,510,893	3,481,422	
Risk Adjusted PPC Rate:	1.09	1.60	
Potentially Avoidable Utilization Costs:	20,395,729	19,633,126	

University MIEMSS

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	202,364,100	188,680,900	181,819,200
Unregulated Services	5,165,260	3,609,000	3,046,000
TOTAL	207,529,360	192,289,900	184,865,200
Net Patient Revenue (NPR):			
Regulated Services	166,218,825	154,423,000	154,091,408
Unregulated Services	5,165,260	3,609,000	3,046,000
TOTAL	171,384,085	158,032,000	157,137,408
Other Operating Revenue:			
Regulated Services	3,126,000	3,091,000	3,263,000
Unregulated Services	0	0	0
TOTAL	3,126,000	3,091,000	3,263,000
Net Operating Revenue (NOR)			
Regulated Services	169,344,825	157,514,000	157,354,408
Unregulated Services	5,165,260	3,609,000	3,046,000
Total	174,510,085	161,123,000	160,400,408
Total Operating Expenses:			
Regulated Services	149,776,000	136,670,900	133,571,300
Total	155,394,000	144,594,000	140,164,000
Net Operating Profit (Loss):			
Regulated Services	19,568,825	20,843,100	23,783,108
Unregulated Services	-452,740	-4,314,100	-3,546,700
Total	19,116,085	16,529,000	20,236,408
Total Non-Operating Profit (Loss):	1,500,000	1,500,000	1,500,000
Non-Operating Revenue	900,000	791,450	1,500,000
Non-Operating Expenses	-600,000	-708,550	0
Total Excess Profit (Loss):	20,616,085	18,029,000	21,736,408
Total Regulated Inpatient Admissions:	5,367	7,874	8,106
Total Regulated Outpatient Visits:	39,079[7]	16,780	17,536

[7] University MIEMSS was approved for an outpatient center allowing for less severe cases to be charged as an outpatient rather than an inpatient admission.

University UMCC

FISCAL YEAR ENDING	June 2014	June 2013	June 2012[8]
Gross Patient Revenue:			
Regulated Services	0	0	59,320,800
Unregulated Services	0	0	0
TOTAL	0	0	59,320,800
Net Patient Revenue (NPR):			
Regulated Services	0	0	51,737,776
Unregulated Services	0	0	0
TOTAL	0	0	51,737,776
Other Operating Revenue:			
Regulated Services	0	0	94,000
Unregulated Services	0	0	0
TOTAL	0	0	94,000
Net Operating Revenue (NOR)			
Regulated Services	0	0	51,831,776
Unregulated Services	0	0	0
Total	0	0	51,831,776
Total Operating Expenses:			
Regulated Services	0	0	57,727,800
Total	0	0	58,704,000
Net Operating Profit (Loss):			
Regulated Services	0	0	-5,896,024
Unregulated Services	0	0	-976,200
Total	0	0	-6,872,224
Total Non-Operating Profit (Loss):	0	0	349,202
Non-Operating Revenue	0	0	335,000
Non-Operating Expenses	0	0	-14,202
Total Excess Profit (Loss):	0	0	-6,523,022
Total Regulated Inpatient Admissions:	0	0	1,534
Total Regulated Outpatient Visits:	0	0	38,043

[8] University UMCC financials were merged with UMMS beginning with FY 2013.

University of Maryland Medical Center

FISCAL YEAR ENDING	June 2014	June 2013[9]	June 2012
Gross Patient Revenue:			
Regulated Services	1,296,211,400	1,241,601,500	1,179,258,000
Unregulated Services	10,519,886	11,074,000	11,002,797
TOTAL	1,306,731,286	1,252,675,500	1,190,260,797
Net Patient Revenue (NPR):			
Regulated Services	1,086,670,121	1,068,680,949	1,016,430,615
Unregulated Services	10,407,916	10,489,051	10,714,232
TOTAL	1,097,078,037	1,079,170,000	1,027,144,847
Other Operating Revenue:			
Regulated Services	18,824,460	36,092,760	13,102,329
Unregulated Services	50,534,530	43,072,240	38,305,671
TOTAL	69,358,990	79,165,000	51,408,000
Net Operating Revenue (NOR)			
Regulated Services	1,105,494,581	1,104,773,709	1,029,532,944
Unregulated Services	60,942,446	53,561,291	49,019,904
Total	1,166,437,027	1,158,335,000	1,078,552,847
Total Operating Expenses:			
Regulated Services	1,060,074,815	1,054,664,631	938,351,058
Total	1,142,114,001	1,123,809,000	1,019,533,500
Net Operating Profit (Loss):			
Regulated Services	45,419,769	50,109,078	91,181,886
Unregulated Services	-21,096,733	-15,583,078	-32,162,539
Total	24,323,036	34,526,000	59,019,347
Total Non-Operating Profit (Loss):	149,439,000	90,290,000	-114,569,797
Non-Operating Revenue	149,439,000	90,290,000	0
Non-Operating Expenses	0	0	114,569,797
Total Excess Profit (Loss):	173,762,036	124,816,000	-55,550,450
Total Regulated Inpatient Admissions:	26,874	26,586	27,143
Total Regulated Outpatient Visits:	247,851	204,962	195,504
Readmission Charges:	113,559,962	100,649,960	
Risk Adjusted Readmission Percent:	15.63%	14.60%	
Potentially Preventable Conditions (PPC) Costs	34,282,646	40,583,574	
Risk Adjusted PPC Rate:	1.09	1.42	
Potentially Avoidable Utilization Costs:	164,464,324	158,111,287	

[9] University UMCC financials were merged with UMMC beginning in FY 2013.

Washington Adventist Hospital

FISCAL YEAR ENDING	December 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	260,306,100	245,900,400	260,716,100
Unregulated Services	3,791	23,951	685,558
TOTAL	260,309,891	245,924,351	261,401,658
Net Patient Revenue (NPR):			
Regulated Services	209,906,016	196,111,014	203,900,463
Unregulated Services	3,791	23,399	682,387
TOTAL	209,909,807	196,134,413	204,582,850
Other Operating Revenue:			
Regulated Services	1,378,906	3,888,835	2,588,088
Unregulated Services	3,547,691	2,651,790	3,107,623
TOTAL	4,926,597	6,540,625	5,695,711
Net Operating Revenue (NOR)			
Regulated Services	211,284,922	199,999,849	206,488,551
Unregulated Services	3,551,482	2,675,189	3,790,010
Total	214,836,404	202,675,038	210,278,561
Total Operating Expenses:			
Regulated Services	194,645,259	199,029,900	203,178,114
Total	210,709,734	213,396,004	216,661,910
Net Operating Profit (Loss):			
Regulated Services	16,639,663	969,949	3,310,437
Unregulated Services	-12,512,993	-11,690,915	-9,693,786
Total	4,126,670	-10,720,966	-6,383,349
Total Non-Operating Profit (Loss):	-1,500,747	-1,509,711	-1,012,274
Non-Operating Revenue	-1,500,747	-1,509,711	-506,403
Non-Operating Expenses	0	0	505,871
Total Excess Profit (Loss):	2,625,923	-12,230,677	-7,395,623
Total Regulated Inpatient Admissions:	11,472	11,648	13,111
Total Regulated Outpatient Visits:	56,831	60,448	61,504
Readmission Charges:	23,064,406	24,244,415	
Risk Adjusted Readmission Percent:	12.50%	12.58%	
Potentially Preventable Conditions (PPC) Costs	7,362,484	7,802,369	
Risk Adjusted PPC Rate:	1.00	1.00	
Potentially Avoidable Utilization Costs:	45,984,233	45,303,339	

Western Maryland Regional M. C.

FISCAL YEAR ENDING	June 2014	June 2013	June 2012
Gross Patient Revenue:			
Regulated Services	317,898,800	314,237,300	308,555,800
Unregulated Services	62,831,500	60,556,700	57,610,800
TOTAL	380,730,300	374,794,000	366,166,600
Net Patient Revenue (NPR):			
Regulated Services	255,447,200	253,404,600	239,944,900
Unregulated Services	37,907,800	37,853,500	43,571,300
TOTAL	293,355,000	291,258,100	283,516,200
Other Operating Revenue:			
Regulated Services	5,313,699	6,605,700	2,672,900
Unregulated Services	2,673,100	2,881,300	2,376,100
TOTAL	7,986,799	9,487,000	5,049,000
Net Operating Revenue (NOR)			
Regulated Services	260,760,899	260,010,300	242,617,800
Unregulated Services	40,580,900	40,734,800	45,947,400
Total	301,341,799	300,745,100	288,565,200
Total Operating Expenses:			
Regulated Services	221,999,899	230,006,375	240,958,708
Total	281,594,900	289,875,700	298,432,900
Net Operating Profit (Loss):			
Regulated Services	38,761,001	30,003,925	1,659,092
Unregulated Services	-19,014,101	-19,134,525	-11,526,792
Total	19,746,900	10,869,400	-9,867,700
Total Non-Operating Profit (Loss):	5,514,799	4,332,300	8,144,000
Non-Operating Revenue	5,514,799	4,332,300	8,144,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	25,261,700	15,201,700	-1,723,700
Total Regulated Inpatient Admissions:	11,805	13,029	13,814
Total Regulated Outpatient Visits:	93,304	96,697	101,271
Readmission Charges:	21,784,662	25,583,028	
Risk Adjusted Readmission Percent:	12.78%	13.70%	
Potentially Preventable Conditions (PPC) Costs	5,052,564	9,317,773	
Risk Adjusted PPC Rate:	0.84	1.37	
Potentially Avoidable Utilization Costs:	40,278,963	49,280,850	

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPTIAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2014-2012

ALL SPECIALTY HOSPITALS

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	312,175,783	357,921,238	393,606,336
Net Patient Revenue (NPR)	239,027,971	285,589,920	318,734,693
Other Operating Revenue	1,139,359	5,057,969	3,403,284
Net Operating Revenue (NOR)	240,167,330	290,647,889	322,137,977
Operating Expenses	228,361,857	266,414,937	327,855,359
Inpatient Admissions (IPAs)	16,658	18,115	18,982
Net Operating Profit (Loss)	11,805,473	24,232,952	(5,717,382)
Total Non-Operating Profit (Loss)	16,932,104	8,279,291	(6,174,190)
Total Excess Profits (Loss)	28,737,577	32,512,243	(11,891,572)

Adventist Behavioral Health – Rockville

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	36,671,700	36,298,100	31,489,200
Net Patient Revenue (NPR)	26,291,671	27,395,522	26,042,739
Other Operating Revenue	66,628	444,774	165,419
Net Operating Revenue (NOR)	26,358,299	27,840,296	26,208,158
Operating Expenses	24,836,429	24,401,558	23,105,596
Inpatient Admissions (IPAs)	2,949	2,705	2,738
Net Operating Profit (Loss)	1,521,870	3,438,738	3,102,562
Total Non-Operating Profit (Loss)	3,402,912	(1,191,069)	(2,598,512)
Total Excess Profits (Loss)	4,924,782	2,247,669	504,050

Adventist Rehab Hospital of MD

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	63,183,083	59,348,989	51,233,400
Net Patient Revenue (NPR)	31,243,964	32,969,459	28,199,348
Other Operating Revenue	393,446	360,155	186,348
Net Operating Revenue (NOR)	31,637,410	33,329,614	28,385,696
Operating Expenses	34,784,403	33,160,136	29,121,717
Inpatient Admissions (IPAs)	1,801	1,574	1,581
Net Operating Profit (Loss)	(3,146,993)	169,478	(736,021)
Total Non-Operating Profit (Loss)	103,663	2,949,432	3,854,931
Total Excess Profits (Loss)	(3,043,330)	3,118,910	3,118,910

Brook Lane Health Services

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	14,512,500	14,918,100	14,051,500
Net Patient Revenue (NPR)	11,103,500	11,758,600	11,264,200
Other Operating Revenue	120,300	124,000	161,300
Net Operating Revenue (NOR)	11,223,800	11,882,600	11,425,500
Operating Expenses	14,386,700	13,962,200	12,618,800
Inpatient Admissions (IPAs)	1677	1,775	1,973
Net Operating Profit (Loss)	(3,162,900)	(2,079,600)	(1,193,300)
Total Non-Operating Profit (Loss)	3,474,000	2,586,800	2,674,000
Total Excess Profits (Loss)	311,100	507,200	1,480,700

Adventist Behavioral Health – Eastern Shore

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	2,409,200	2,508,000	2,457,650
Net Patient Revenue (NPR)	1,896,662	2,045,654	2,101,900
Other Operating Revenue	0	0	0
Net Operating Revenue (NOR)	1,896,662	2,045,654	2,101,900
Operating Expenses	576,673	616,191	1,000,156
Inpatient Admissions (IPAs)	297	271	304
Net Operating Profit (Loss)	1,319,989	1,429,463	1,101,744
Total Non-Operating Profit (Loss)	0	0	0
Total Excess Profits (Loss)	1,319,989	1,429,463	1,101,744

Levindale Hospital

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
	*Under Acute		
Gross Patient Revenue		53,610,200	52,498,900
Net Patient Revenue (NPR)		48,264,286	49,039,494
Other Operating Revenue		1,779,100	1,990,000
Net Operating Revenue (NOR)		50,043,386	51,029,494
Operating Expenses		44,401,061	43,340,924
Inpatient Admissions (IPAs)		1,324	1,578
Net Operating Profit (Loss)		5,642,325	7,688,570
Total Non-Operating Profit (Loss)		(3,534,070)	(7,177,520)
Total Excess Profits (Loss)		2,108,255	511,050

Mt. Washington Pediatric Hospital

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	55,464,000	53,308,449	49,446,660
Net Patient Revenue (NPR)	50,598,699	49,434,005	45,713,951
Other Operating Revenue	1,356,678	2,432,381	444,185
Net Operating Revenue (NOR)	51,955,377	51,866,386	46,158,136
Operating Expenses	44,459,476	42,963,622	40,690,987
Inpatient Admissions (IPAs)	795	790	691
Net Operating Profit (Loss)	7,495,901	8,902,764	5,467,149
Total Non-Operating Profit (Loss)	893,535	(1,320,561)	(3,419,720)
Total Excess Profits (Loss)	8,389,436	7,582,203	2,047,429

Sheppard Pratt Hospital

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	139,935,300	137,929,400	140,136,100
Net Patient Revenue (NPR)	117,893,475	113,722,394	111,243,237
Other Operating Revenue	(797,693)	(82,441)	206,952
Net Operating Revenue (NOR)	117,095,782	113,639,954	111,450,189
Operating Expenses	109,318,177	106,910,170	108,750,802
Inpatient Admissions (IPAs)	9,139	9,676	9,389
Net Operating Profit (Loss)	7,777,606	6,729,784	2,699,387
Total Non-Operating Profit (Loss)	9,057,994	8,788,759	(41,437)
Total Excess Profits (Loss)	16,835,600	15,518,543	2,657,950

St. Luke Institute

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	0	0	6,213,526
Net Patient Revenue (NPR)	0	0	6,171,824
Other Operating Revenue	0	0	249,127
Net Operating Revenue (NOR)	0	0	6,420,951
Operating Expenses	0	0	7,420,561
Inpatient Admissions (IPAs)	0	0	83
Net Operating Profit (Loss)	0	0	(999,610)
Total Non-Operating Profit (Loss)	0	0	2,997,905
Total Excess Profits (Loss)	0	0	1,998,295

University Specialty Hospital

FISCAL YEAR ENDING	YEAR 2014	YEAR 2013	YEAR 2012
Gross Patient Revenue	0	0	46,079,400
Net Patient Revenue (NPR)	0	0	38,958,000
Other Operating Revenue	0	0	(47)
Net Operating Revenue (NOR)	0	0	38,957,953
Operating Expenses	0	0	61,805,816
Inpatient Admissions (IPAs)	0	0	645
Net Operating Profit (Loss)	0	0	(22,847,863)
Total Non-Operating Profit (Loss)	0	0	(2,463,837)
Total Excess Profits (Loss)	0	0	(25,311,700)

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

		2013			2014			
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	541,867,800	28,229,300	5.21	554,132,400	28,030,100	5.06	-0.7
	Bon Secours Hospital	121,044,100	21,934,644	18.12	129,714,300	18,907,653	14.58	-13.8
	Bowie Emergency Center	13,677,900	3,095,262	22.63	16,513,400	3,176,307	19.23	2.6
	Doctors Community Hospital	216,854,500	20,137,582	9.29	222,145,400	21,083,439	9.49	4.7
	Fort Washington Medical Center	46,156,625	6,289,082	13.63	48,565,970	5,271,258	10.85	-16.2
	Germantown Emergency Center	12,992,000	3,426,331	26.37	14,059,900	2,928,631	20.83	-14.5
	Greater Baltimore Medical Center	421,137,700	13,135,500	3.12	426,965,000	14,448,600	3.38	10.0
	Holy Cross Hospital	461,351,200	42,720,100	9.26	468,876,700	41,181,900	8.78	-3.6
	Howard County General Hospital	278,901,600	16,701,844	5.99	281,805,600	15,945,000	5.66	-4.5
	Johns Hopkins Bayview Medical Center	596,807,300	55,404,000	9.28	605,106,300	53,366,000	8.82	-3.7
	Johns Hopkins Hospital	2,132,419,000	90,951,400	4.27	2,172,517,900	90,418,800	4.16	-0.6
	Laurel Regional Hospital	121,542,100	17,298,770	14.23	118,865,000	13,262,786	11.16	-23.3
	Levindale[10]	0	0	0	54,541,800	1,645,534	3.02	N/A
	MedStar Franklin Square	469,792,200	33,165,956	7.06	486,467,000	28,840,763	5.93	-13.0
	MedStar Good Samaritan	295,736,800	19,525,089	6.60	299,250,000	18,307,883	6.12	-6.2
	MedStar Harbor Hospital	201,141,000	17,275,577	8.59	205,146,300	12,384,997	6.04	-28.3
	MedStar Montgomery General	166,869,100	10,997,703	6.59	167,893,100	9,139,362	5.44	-16.9
	MedStar Southern Maryland	259,132,417	17,742,561	6.85	261,812,300	21,607,448	8.25	21.8
	MedStar Union Memorial	406,581,900	33,074,497	8.13	415,164,300	23,163,918	5.58	-30.0
	Mercy Medical Center	470,759,600	39,008,070	8.29	489,187,300	39,462,900	8.07	1.2

[10] FY14 is the first year that Levindale was designated as an acute care hospital by CMS.

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

		2013			2014			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
	Northwest Hospital Center	248,252,700	20,881,783	8.41	249,134,500	19,327,600	7.76	-7.4
	Prince Georges' Hospital Center	249,192,555	38,639,516	15.51	267,282,400	34,867,927	13.05	-9.8
	Queen Anne's Emergency Center	4,999,900	246,148	4.92	5,190,800	327,866	6.32	33.2
	Saint Agnes Hospital	404,669,900	32,203,974	7.96	410,191,100	25,327,088	6.17	-21.4
	Shady Grove Adventist Hospital	375,189,800	25,364,171	6.76	383,323,300	29,442,581	7.68	16.1
	Sinai Hospital of Baltimore	684,516,800	37,059,900	5.41	699,430,000	42,571,600	6.09	14.9
	Suburban Hospital	280,578,500	14,223,180	5.07	289,286,600	12,582,100	4.35	-11.5
	UM Baltimore Washington	376,812,800	36,844,300	9.78	393,181,900	31,494,716	8.01	-14.5
	UM Midtown	216,173,800	32,903,997	15.22	222,427,600	33,531,633	15.08	1.9
	UM Rehabilitation & Orthopedic Institute	115,227,400	5,988,426	5.20	118,262,200	8,436,183	7.13	40.9
	UM Saint Joseph	337,661,500	17,305,468	5.13	362,415,700	22,836,124	6.30	32.0
	UM Upper Chesapeake[11]	290,000,800	17,640,400	6.08	157,472,100	8,242,700	5.23	N/A
	University MIEMSS	188,680,900	42,108,564	22.32	202,364,100	40,596,352	20.06	-3.6
	University of Maryland Medical Center	1,241,601,500	67,006,535	5.40	1,296,211,400	71,156,193	5.49	6.2
	Washington Adventist Hospital	245,900,400	34,627,375	14.08	260,306,100	31,746,079	12.20	-8.3
M E T R O[12]		*12,204,223,297*	*895,516,605*	*7.34*	*12,543,195,870*	*865,171,787*	*6.90*	*-3.4*

[11] UM Upper Chesapeake changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.
[12] The Metro summary line excludes Levindale and UM Upper Chesapeake hospitals.

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

		2013			2014			
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	99,487,100	7,638,100	7.68	102,693,200	7,165,200	6.98	-6.2
	Calvert Memorial Hospital	138,862,900	8,548,160	6.16	141,935,300	9,268,967	6.53	8.4
	Carroll County General Hospital	249,075,200	11,694,600	4.70	251,985,400	11,185,592	4.44	-4.4
	Frederick Memorial Hospital	337,093,700	20,318,595	6.03	339,660,800	22,831,994	6.72	12.4
	Garrett County Memorial Hospital	42,302,400	4,593,416	10.86	45,202,600	4,192,263	9.27	-8.7
	McCready Hospital	17,975,600	1,495,267	8.32	16,638,000	1,412,273	8.49	-5.6
	MedStar Saint Mary's Hospital	154,603,000	13,099,310	8.47	157,936,000	8,667,483	5.49	-33.8
	Meritus Medical Center	301,350,700	21,682,200	7.20	305,141,600	22,551,500	7.39	4.0
	Peninsula Regional Medical Center	412,641,500	28,334,500	6.87	416,388,900	24,743,900	5.94	-12.7
	UM Charles Regional Medical Center	137,003,900	10,219,211	7.46	144,785,724	10,881,673	7.52	6.5
	UM Harford Memorial Hospital[13]	103,499,300	12,876,361	12.44	53,719,100	5,242,600	9.76	N/A
	UM Shore Medical Chestertown	62,791,800	6,363,467	10.13	64,508,977	6,551,013	10.16	2.9
	UM Shore Medical Dorchester	59,897,900	4,186,127	6.99	58,994,300	5,504,997	9.33	31.5
	UM Shore Medical Easton	186,358,600	10,916,970	5.86	187,483,400	11,857,425	6.32	8.6
	Union Hospital of Cecil County	153,372,900	13,323,600	8.69	157,913,800	12,201,400	7.73	-8.4
	Western Maryland Regional M. C.	314,237,300	21,637,900	6.89	317,898,800	20,653,700	6.50	-4.5
R U R A L[14]		*2,667,054,500*	*184,051,423*	*6.90*	*2,709,166,801*	*179,669,380*	*6.63*	*-2.4*
T O T A L[15]	All Acute Hospitals	***14,871,277,797***	***1,079,568,028***	***7.26***	***15,252,362,671***	***1,044,841,167***	***6.85***	***-3.2***

[13] UM Harford Memorial changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.
[14] The Rural summary line excludes UM Harford Memorial
[15] The total line excludes Levindale, UM Harford Memorial, and UM Upper Chesapeake Hospitals.

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

		2013			2014			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
M E T R O	Germantown Emergency Center	**12,992,000**	**3,426,331**	**26.37**	14,059,900	2,928,631	20.83	-14.5
	University MIEMSS	**188,680,900**	**42,108,564**	**22.32**	202,364,100	40,596,352	20.06	-3.6
	Bowie Emergency Center	**13,677,900**	**3,095,262**	**22.63**	16,513,400	3,176,307	19.23	2.6
	UM Midtown	**216,173,800**	**32,903,997**	**15.22**	222,427,600	33,531,633	15.08	1.9
	Bon Secours Hospital	**121,044,100**	**21,934,644**	**18.12**	129,714,300	18,907,653	14.58	-13.8
	Prince Georges' Hospital Center	**249,192,555**	**38,639,516**	**15.51**	267,282,400	34,867,927	13.05	-9.8
	Washington Adventist Hospital	**245,900,400**	**34,627,375**	**14.08**	260,306,100	31,746,079	12.20	-8.3
	Laurel Regional Hospital	**121,542,100**	**17,298,770**	**14.23**	118,865,000	13,262,786	11.16	-23.3
	Fort Washington Medical Center	**46,156,625**	**6,289,082**	**13.63**	48,565,970	5,271,258	10.85	-16.2
	Doctors Community Hospital	**216,854,500**	**20,137,582**	**9.29**	222,145,400	21,083,439	9.49	4.7
	Johns Hopkins Bayview Medical Center	**596,807,300**	**55,404,000**	**9.28**	605,106,300	53,366,000	8.82	-3.7
	Holy Cross Hospital	**461,351,200**	**42,720,100**	**9.26**	468,876,700	41,181,900	8.78	-3.6
	MedStar Southern Maryland	**259,132,417**	**17,742,561**	**6.85**	261,812,300	21,607,448	8.25	21.8
	Mercy Medical Center	**470,759,600**	**39,008,070**	**8.29**	489,187,300	39,462,900	8.07	1.2
	UM Baltimore Washington	**376,812,800**	**36,844,300**	**9.78**	393,181,900	31,494,716	8.01	-14.5
	Northwest Hospital Center	**248,252,700**	**20,881,783**	**8.41**	249,134,500	19,327,600	7.76	-7.4
	Shady Grove Adventist Hospital	**375,189,800**	**25,364,171**	**6.76**	383,323,300	29,442,581	7.68	16.1
	UM Rehabilitation & Orthopedic Institute	**115,227,400**	**5,988,426**	**5.20**	118,262,200	8,436,183	7.13	40.9
	Queen Anne’s Emergency Center	**4,999,900**	**246,148**	**4.92**	5,190,800	327,866	6.32	33.2
	UM Saint Joseph	**337,661,500**	**17,305,468**	**5.13**	362,415,700	22,836,124	6.30	32.0

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

		2013			2014			
	Saint Agnes Hospital	**404,669,900**	**32,203,974**	**7.96**	410,191,100	25,327,088	6.17	-21.4
	MedStar Good Samaritan	**295,736,800**	**19,525,089**	**6.60**	299,250,000	18,307,883	6.12	-6.2
	Sinai Hospital of Baltimore	**684,516,800**	**37,059,900**	**5.41**	699,430,000	42,571,600	6.09	14.9
	MedStar Harbor Hospital	**201,141,000**	**17,275,577**	**8.59**	205,146,300	12,384,997	6.04	-28.3
	MedStar Franklin Square	**469,792,200**	**33,165,956**	**7.06**	486,467,000	28,840,763	5.93	-13.0
	Howard County General Hospital	**278,901,600**	**16,701,844**	**5.99**	281,805,600	15,945,000	5.66	-4.5
	MedStar Union Memorial	**406,581,900**	**33,074,497**	**8.13**	415,164,300	23,163,918	5.58	-30.0
	University of Maryland Medical Center	**1,241,601,500**	**67,006,535**	**5.40**	1,296,211,400	71,156,193	5.49	6.2
	MedStar Montgomery General	**166,869,100**	**10,997,703**	**6.59**	167,893,100	9,139,362	5.44	-16.9
	UM Upper Chesapeake[16]	**290,000,800**	**17,640,400**	**6.08**	157,472,100	8,242,700	5.23	N/A
	Anne Arundel Medical Center	**541,867,800**	**28,229,300**	**5.21**	554,132,400	28,030,100	5.06	-0.7
	Suburban Hospital	**280,578,500**	**14,223,180**	**5.07**	289,286,600	12,582,100	4.35	-11.5
	Johns Hopkins Hospital	**2,132,419,000**	**90,951,400**	**4.27**	2,172,517,900	90,418,800	4.16	-0.6
	Greater Baltimore Medical Center	**421,137,700**	**13,135,500**	**3.12**	426,965,000	14,448,600	3.38	10.0
	Levindale[17]	**0**	**0**	**0**	54,541,800	1,645,534	3.02	N/A
M E T R O[18]		**12,204,223,297**	**895,516,605**	**7.34**	*12,543,195,870*	*865,171,787*	*6.90*	*-3.4*

[16] UM Upper Chesapeake changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.
[17] FY14 is the first year that Levindale was designed as an acute care hospital by CMS.
[18] The Metro summary line excludes Levindale and UM Upper Chesapeake hospitals.

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

		2013			2014			
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 Medical Chestertown	62,791,800	6,363,467	10.13	64,508,977	6,551,013	10.16	2.9
	UM Harford Memorial Hospital[19]	103,499,300	12,876,361	12.44	53,719,100	5,242,600	9.76	N/A
	UM Shore Medical Dorchester	59,897,900	4,186,127	6.99	58,994,300	5,504,997	9.33	31.5
	Garrett County Memorial Hospital	42,302,400	4,593,416	10.86	45,202,600	4,192,263	9.27	-8.7
	McCready Hospital	17,975,600	1,495,267	8.32	16,638,000	1,412,273	8.49	-5.6
	Union Hospital of Cecil County	153,372,900	13,323,600	8.69	157,913,800	12,201,400	7.73	-8.4
	UM Charles Regional Medical Center	137,003,900	10,219,211	7.46	144,785,724	10,881,673	7.52	6.5
	Meritus Medical Center	301,350,700	21,682,200	7.20	305,141,600	22,551,500	7.39	4.0
	Atlantic General Hospital	99,487,100	7,638,100	7.68	102,693,200	7,165,200	6.98	-6.2
	Frederick Memorial Hospital	337,093,700	20,318,595	6.03	339,660,800	22,831,994	6.72	12.4
	Calvert Memorial Hospital	138,862,900	8,548,160	6.16	141,935,300	9,268,967	6.53	8.4
	Western Maryland Regional M. C.	314,237,300	21,637,900	6.89	317,898,800	20,653,700	6.50	-4.5
	UM Shore Medical Easton	186,358,600	10,916,970	5.86	187,483,400	11,857,425	6.32	8.6
	Peninsula Regional Medical Center	412,641,500	28,334,500	6.87	416,388,900	24,743,900	5.94	-12.7
	MedStar Saint Mary's Hospital	154,603,000	13,099,310	8.47	157,936,000	8,667,483	5.49	-33.8
	Carroll County General Hospital	249,075,200	11,694,600	4.70	251,985,400	11,185,592	4.44	-4.4
R U R A L[20]		*2,667,054,500*	*184,051,423*	*6.90*	*2,709,166,801*	*179,669,380*	*6.63*	*-2.4*
T O T A L[21]	All Acute Hospitals	***14,871,277,797***	***1,079,568,028***	***7.26***	***15,252,362,671***	***1,044,841,167***	***6.85***	***-3.2***

[19] UM Harford Memorial changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.
[20] The Rural summary line excludes UM Harford Memorial
[21] The Total line excludes Levindale, UM Harford Memorial, and UM Upper Chesapeake Hospitals.

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

	2013			2014				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
All Acute Hospitals[22]	646,386,668	-505,178,997	141,207,673	913,178,165	-516,346,047	396,832,119	41.27	181.03
Anne Arundel Medical Center	16,002,451	-14,887,851	1,114,600	25,326,003	-13,213,903	12,112,100	58.26	986.68
Atlantic General Hospital	9,222,349	-7,995,621	1,226,727	8,601,500	-10,086,613	-1,485,113	-6.73	-221.06
Bon Secours Hospital	2,560,429	-13,579,925	-11,019,496	15,956,273	-13,952,517	2,003,755	523.19	118.18
Bowie Emergency Center	-945,065	-208,041	-1,153,106	1,943,397	34,401	1,977,798	305.64	271.52
Calvert Memorial Hospital	14,541,508	-7,631,293	6,910,215	16,797,976	-8,340,143	8,457,833	15.52	22.40
Carroll County General Hospital	25,286,993	-5,037,706	20,249,287	26,236,823	-5,435,765	20,801,058	3.76	2.72
Doctors Community Hospital	4,422,646	-7,140,124	-2,717,478	10,251,378	-9,356,366	895,012	131.79	132.94
Fort Washington Medical Center	1,223,777	-648,495	575,282	2,028,867	-648,722	1,380,145	65.79	139.91
Frederick Memorial Hospital	17,216,148	-17,819,196	-603,048	16,325,142	-13,195,104	3,130,038	-5.18	619.04
Garrett County Memorial Hospital	2,570,135	-1,284,004	1,286,131	4,171,544	-810,322	3,361,223	62.31	161.34
Germantown Emergency Center	-1,690,370	-195,557	-1,885,927	-1,882,264	-37,105	-1,919,369	-11.35	-1.77
Greater Baltimore Medical Center	29,521,863	-14,587,186	14,934,677	30,962,700	-10,118,000	20,844,700	4.88	39.57
Holy Cross Hospital	42,986,566	-18,836,520	24,150,046	41,046,525	-17,751,525	23,295,000	-4.51	-3.54
Howard County General Hospital	18,538,282	-7,841,142	10,697,140	10,395,296	-6,818,406	3,576,890	-43.93	-66.56
Johns Hopkins Bayview Medical Center	5,832,881	-13,886,881	-8,054,000	21,241,512	-11,823,012	9,418,500	264.17	216.94
Johns Hopkins Hospital	17,927,223	-1,959,024	15,968,199	24,951,117	6,477,361	31,428,478	39.18	96.82
Laurel Regional Hospital	-2,910,849	-7,359,314	-10,270,163	-3,598,137	-5,637,852	-9,235,989	-23.61	10.07
Levindale[23]	0	0	0	7,214,700	-3,988,800	3,225,900	N/A	N/A

[22] The All Acute Hospitals line excludes Levindale, UM Harford Memorial, and UM Upper Chesapeake Hospitals.
[23] FY14 is the first year that Levindale was designed as an acute care hospital by CMS.

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

	2013			2014				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
McCready Hospital	-298,269	763,412	465,143	2,347,500	-583,451	1,764,049	887.04	279.25
MedStar Franklin Square	26,574,956	-26,514,792	60,164	40,797,801	-19,480,307	21,317,494	53.52	35332.31
MedStar Good Samaritan	12,773,906	-20,971,324	-8,197,418	25,433,656	-21,465,032	3,968,625	99.11	148.41
MedStar Harbor Hospital	12,288,534	-6,504,729	5,783,805	29,901,331	-9,668,488	20,232,843	143.33	249.82
MedStar Montgomery General	16,850,341	-9,763,710	7,086,631	14,950,082	-7,889,606	7,060,476	-11.28	-0.37
MedStar Saint Mary's Hospital	16,308,891	-6,063,773	10,245,118	20,371,965	-8,870,208	11,501,757	24.91	12.27
MedStar Southern Maryland	-21,613,758	-6,037,146	-27,650,904	3,162,651	-8,766,828	-5,604,177	114.63	79.73
MedStar Union Memorial	20,335,376	-26,559,115	-6,223,738	46,312,220	-31,775,042	14,537,178	127.74	333.58
Mercy Medical Center	15,429,893	-12,365,317	3,064,576	14,111,314	-7,804,301	6,307,013	-8.55	105.80
Meritus Medical Center	10,308,554	755,874	11,064,428	4,717,300	-220,400	4,496,900	-54.24	-59.36
Northwest Hospital Center	19,846,980	-6,563,890	13,283,090	23,464,469	-14,008,165	9,456,304	18.23	-28.81
Peninsula Regional Medical Center	25,869,524	-29,004,524	-3,135,000	36,419,854	-28,728,854	7,691,000	40.78	345.33
Prince Georges' Hospital Center	-2,474,588	-18,839,314	-21,313,902	4,536,729	-23,670,492	-19,133,763	283.33	10.23
Queen Anne’s Emergency Center	-3,508,488	0	-3,508,488	-3,317,840	0	-3,317,840	5.43	5.43
Saint Agnes Hospital	55,452,969	-29,226,624	26,226,345	53,398,364	-29,462,430	23,935,933	-3.71	-8.73
Shady Grove Adventist Hospital	28,935,249	-13,410,889	15,524,360	31,683,154	-14,534,203	17,148,951	9.50	10.46
Sinai Hospital of Baltimore	50,470,369	-35,170,451	15,299,918	60,556,006	-32,615,013	27,940,993	19.98	82.62
Suburban Hospital	20,495,552	13,276,817	33,772,370	17,164,544	-14,538,791	2,625,753	-16.25	-92.23
UM Baltimore Washington	2,919,627	-7,324,899	-4,405,272	26,085,945	-9,715,260	16,370,685	793.47	471.62
UM Charles Regional Medical Center	11,700,484	-1,700,312	10,000,172	12,894,884	-1,897,862	10,997,022	10.21	9.97

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

	2013			2014				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
UM Harford Memorial Hospital[24]	6,070,368	-1,886,029	4,184,339	6,252,500	-1,463,100	4,789,400	N/A	N/A
UM Midtown	17,952,942	-21,205,328	-3,252,386	22,996,711	-19,319,509	3,677,202	28.09	213.06
UM Rehabilitation & Orthopedic Institute	-698,160	-592,139	-1,290,298	1,364,808	-831,695	533,113	295.49	141.32
UM Saint Joseph	-32,370,924	-33,481,543	-65,852,468	7,708,617	-16,426,617	-8,718,000	123.81	86.76
UM Shore Medical Chestertown	1,403,716	-1,589,533	-185,817	8,334,074	-2,753,782	5,580,293	493.72	3103.12
UM Shore Medical Dorchester	8,347,091	-2,093,218	6,253,874	8,281,878	-1,845,477	6,436,401	-0.78	2.92
UM Shore Medical Easton	13,099,182	-2,730,332	10,368,850	13,445,938	-4,147,074	9,298,864	2.65	-10.32
UM Upper Chesapeake[25]	24,437,959	-6,159,959	18,278,000	23,598,700	-4,239,800	19,358,900	N/A	N/A
Union Hospital of Cecil County	15,753,700	-10,641,700	5,112,000	14,909,300	-11,537,000	3,372,300	-5.36	-34.03
University MIEMSS	20,843,100	-4,314,100	16,529,000	19,568,825	-452,740	19,116,085	-6.11	15.65
University of Maryland Medical Center	50,109,078	-15,583,078	34,526,000	45,419,769	-21,096,733	24,323,036	-9.36	-29.55
Washington Adventist Hospital	969,949	-11,690,915	-10,720,966	16,639,663	-12,512,993	4,126,670	1615.52	138.49
Western Maryland Regional Medical Center	30,003,925	-19,134,525	10,869,400	38,761,001	-19,014,101	19,746,900	29.19	81.67

[24] UM Harford Memorial changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.
[25] UM Upper Chesapeake changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.

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

	2013			2014				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
All Acute Hospitals[26]	646,386,668	-505,178,997	141,207,673	913,178,165	-516,346,047	396,832,119	41.27	181.03
Johns Hopkins Hospital	17,927,223	-1,959,024	15,968,199	24,951,117	6,477,361	31,428,478	39.18	96.82
Sinai Hospital of Baltimore	50,470,369	-35,170,451	15,299,918	60,556,006	-32,615,013	27,940,993	19.98	82.62
University of Maryland Medical Center	50,109,078	-15,583,078	34,526,000	45,419,769	-21,096,733	24,323,036	-9.36	-29.55
Saint Agnes Hospital	55,452,969	-29,226,624	26,226,345	53,398,364	-29,462,430	23,935,933	-3.71	-8.73
Holy Cross Hospital	42,986,566	-18,836,520	24,150,046	41,046,525	-17,751,525	23,295,000	-4.51	-3.54
MedStar Franklin Square	26,574,956	-26,514,792	60,164	40,797,801	-19,480,307	21,317,494	53.52	35332.31
Greater Baltimore Medical Center	29,521,863	-14,587,186	14,934,677	30,962,700	-10,118,000	20,844,700	4.88	39.57
Carroll County General Hospital	25,286,993	-5,037,706	20,249,287	26,236,823	-5,435,765	20,801,058	3.76	2.72
MedStar Harbor Hospital	12,288,534	-6,504,729	5,783,805	29,901,331	-9,668,488	20,232,843	143.33	249.82
Western Maryland Regional M. C.	30,003,925	-19,134,525	10,869,400	38,761,001	-19,014,101	19,746,900	29.19	81.67
UM Upper Chesapeake[27]	24,437,959	-6,159,959	18,278,000	23,598,700	-4,239,800	19,358,900	-3.43	5.91
University MIEMSS	20,843,100	-4,314,100	16,529,000	19,568,825	-452,740	19,116,085	-6.11	15.65
Shady Grove Adventist Hospital	28,935,249	-13,410,889	15,524,360	31,683,154	-14,534,203	17,148,951	9.50	10.46
UM Baltimore Washington	2,919,627	-7,324,899	-4,405,272	26,085,945	-9,715,260	16,370,685	793.47	471.62
MedStar Union Memorial	20,335,376	-26,559,115	-6,223,738	46,312,220	-31,775,042	14,537,178	127.74	333.58
Anne Arundel Medical Center	16,002,451	-14,887,851	1,114,600	25,326,003	-13,213,903	12,112,100	58.26	986.68
MedStar Saint Mary's Hospital	16,308,891	-6,063,773	10,245,118	20,371,965	-8,870,208	11,501,757	24.91	12.27
UM Charles Regional Medical Center	11,700,484	-1,700,312	10,000,172	12,894,884	-1,897,862	10,997,022	10.21	9.97

[26] The All Acute Hospitals line excludes Levindale, UM Harford Memorial, and UM Upper Chesapeake Hospitals.
[27] UM Upper Chesapeake changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.

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

	2013			2014				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
Northwest Hospital Center	19,846,980	-6,563,890	13,283,090	23,464,469	-14,008,165	9,456,304	18.23	-28.81
Johns Hopkins Bayview Medical Center	5,832,881	-13,886,881	-8,054,000	21,241,512	-11,823,012	9,418,500	264.17	216.94
UM Shore Medical Easton	13,099,182	-2,730,332	10,368,850	13,445,938	-4,147,074	9,298,864	2.65	-10.32
Calvert Memorial Hospital	14,541,508	-7,631,293	6,910,215	16,797,976	-8,340,143	8,457,833	15.52	22.40
Peninsula Regional Medical Center	25,869,524	-29,004,524	-3,135,000	36,419,854	-28,728,854	7,691,000	40.78	345.33
MedStar Montgomery General	16,850,341	-9,763,710	7,086,631	14,950,082	-7,889,606	7,060,476	-11.28	-0.37
UM Shore Medical Dorchester	8,347,091	-2,093,218	6,253,874	8,281,878	-1,845,477	6,436,401	-0.78	2.92
Mercy Medical Center	15,429,893	-12,365,317	3,064,576	14,111,314	-7,804,301	6,307,013	-8.55	105.80
UM Shore Medical Chestertown	1,403,716	-1,589,533	-185,817	8,334,074	-2,753,782	5,580,293	493.72	3103.12
UM Harford Memorial Hospital[28]	6,070,368	-1,886,029	4,184,339	6,252,500	-1,463,100	4,789,400	N/A	N/A
Meritus Medical Center	10,308,554	755,874	11,064,428	4,717,300	-220,400	4,496,900	-54.24	-59.36
Washington Adventist Hospital	969,949	-11,690,915	-10,720,966	16,639,663	-12,512,993	4,126,670	1615.52	138.49
MedStar Good Samaritan	12,773,906	-20,971,324	-8,197,418	25,433,656	-21,465,032	3,968,625	99.11	148.41
UM Midtown	17,952,942	-21,205,328	-3,252,386	22,996,711	-19,319,509	3,677,202	28.09	213.06
Howard County General Hospital	18,538,282	-7,841,142	10,697,140	10,395,296	-6,818,406	3,576,890	-43.93	-66.56
Union Hospital of Cecil County	15,753,700	-10,641,700	5,112,000	14,909,300	-11,537,000	3,372,300	-5.36	-34.03
Garrett County Memorial Hospital	2,570,135	-1,284,004	1,286,131	4,171,544	-810,322	3,361,223	62.31	161.34
Levindale[29]	0	0	0	7,214,700	-3,988,800	3,225,900	N/A	N/A
Frederick Memorial Hospital	17,216,148	-17,819,196	-603,048	16,325,142	-13,195,104	3,130,038	-5.18	619.04

[28] UM Harford Memorial changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.
[29] FY14 is the first year that Levindale was designed as an acute care hospital by CMS.

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

	2013			2014				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
Suburban Hospital	20,495,552	13,276,817	33,772,370	17,164,544	-14,538,791	2,625,753	-16.25	-92.23
Bon Secours Hospital	2,560,429	-13,579,925	-11,019,496	15,956,273	-13,952,517	2,003,755	523.19	118.18
Bowie Emergency Center	-945,065	-208,041	-1,153,106	1,943,397	34,401	1,977,798	305.64	271.52
McCready Hospital	-298,269	763,412	465,143	2,347,500	-583,451	1,764,049	887.04	279.25
Fort Washington Medical Center	1,223,777	-648,495	575,282	2,028,867	-648,722	1,380,145	65.79	139.91
Doctors Community Hospital	4,422,646	-7,140,124	-2,717,478	10,251,378	-9,356,366	895,012	131.79	132.94
UM Rehabilitation & Orthopedic Institute	-698,160	-592,139	-1,290,298	1,364,808	-831,695	533,113	295.49	141.32
Atlantic General Hospital	9,222,349	-7,995,621	1,226,727	8,601,500	-10,086,613	-1,485,113	-6.73	-221.06
Germantown Emergency Center	-1,690,370	-195,557	-1,885,927	-1,882,264	-37,105	-1,919,369	-11.35	-1.77
Queen Anne’s Emergency Center	-3,508,488	0	-3,508,488	-3,317,840	0	-3,317,840	5.43	5.43
MedStar Southern Maryland	-21,613,758	-6,037,146	-27,650,904	3,162,651	-8,766,828	-5,604,177	114.63	79.73
UM Saint Joseph	-32,370,924	-33,481,543	-65,852,468	7,708,617	-16,426,617	-8,718,000	123.81	86.76
Laurel Regional Hospital	-2,910,849	-7,359,314	-10,270,163	-3,598,137	-5,637,852	-9,235,989	-23.61	10.07
Prince Georges' Hospital Center	-2,474,588	-18,839,314	-21,313,902	4,536,729	-23,670,492	-19,133,763	283.33	10.23

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

	2013	2014	
Hospital	**Excess Profit/Loss**	**Excess Profit/Loss**	**% Change in Excess**
All Acute Hospitals[30]	515,138,415	867,825,669	68.46
Anne Arundel Medical Center	45,341,200	39,203,200	-13.54
Atlantic General Hospital	2,725,952	976,248	-64.19
Bon Secours Hospital	-9,627,191	3,569,505	137.08
Bowie Emergency Center	-1,153,106	1,977,798	271.52
Calvert Memorial Hospital	6,916,629	6,802,728	-1.65
Carroll County General Hospital	30,673,703	27,155,986	-11.47
Doctors Community Hospital	-1,415,078	651,801	146.06
Fort Washington Medical Center	576,030	1,380,752	139.70
Frederick Memorial Hospital	10,738,933	16,993,038	58.24
Garrett County Memorial Hospital	2,041,070	4,238,955	107.68
Germantown Emergency Center	-2,264,592	-2,327,154	-2.76
Greater Baltimore Medical Center	33,230,610	40,539,700	22.00
Holy Cross Hospital	37,428,046	46,558,000	24.39
Howard County General Hospital	19,389,706	9,886,601	-49.01
Johns Hopkins Bayview Medical Center	-6,796,000	11,105,000	263.40
Johns Hopkins Hospital	51,063,077	66,850,174	30.92
Laurel Regional Hospital	-1,570,163	-685,989	56.31
Levindale[31]	0	6,801,826	N/A
McCready Hospital	429,845	1,871,567	335.40
MedStar Franklin Square	425,534	21,563,555	4967.41
MedStar Good Samaritan	-8,126,384	3,971,844	148.88
MedStar Harbor Hospital	6,061,104	20,739,733	242.18
MedStar Montgomery General	7,262,526	7,075,846	-2.57
MedStar Saint Mary's Hospital	12,348,616	12,271,586	-0.62
MedStar Southern Maryland	-21,613,758	-5,582,219	74.17
MedStar Union Memorial	-1,472,759	20,389,661	1484.45
Mercy Medical Center	31,020,207	16,016,399	-48.37
Meritus Medical Center	9,116,228	18,982,900	108.23

[30] The All Acute Hospitals line excludes Levindale, UM Harford Memorial, and UM Upper Chesapeake Hospitals.
[31] FY14 is the first year that Levindale was designed as an acute care hospital by CMS.

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

	2013	2014	
Hospital	**Excess Profit/Loss**	**Excess Profit/Loss**	**% Change in Excess**
Northwest Hospital Center	23,613,990	25,618,214	8.49
Peninsula Regional Medical Center	10,719,000	29,420,000	174.47
Prince Georges' Hospital Center	1,028,098	3,192,390	210.51
Queen Anne's Emergency Center	-3,458,234	-3,347,238	3.21
Saint Agnes Hospital	41,883,345	44,871,382	7.13
Shady Grove Adventist Hospital	15,263,693	18,326,992	20.07
Sinai Hospital of Baltimore	34,266,918	57,740,993	68.50
Suburban Hospital	38,134,858	16,401,687	-56.99
UM Baltimore Washington	-4,380,643	19,474,047	544.55
UM Charles Regional Medical Center	4,734,172	10,169,022	114.80
UM Harford Memorial Hospital[32]	11,524,339	6,704,700	N/A
UM Midtown	-3,684,386	3,078,202	183.55
UM Rehabilitation & Orthopedic Institute	-385,298	1,802,113	567.72
UM Saint Joseph	-72,512,468	-14,131,000	80.51
UM Shore Medical Chestertown	1,065,985	6,550,008	514.46
UM Shore Medical Dorchester	6,630,853	6,224,482	-6.13
UM Shore Medical Easton	14,371,024	17,180,916	19.55
UM Upper Chesapeake[33]	22,400,000	19,546,400	N/A
Union Hospital of Cecil County	9,281,500	10,810,500	16.47
University MIEMSS	18,029,000	20,616,085	14.35
University of Maryland Medical Center	124,816,000	173,762,036	39.21
Washington Adventist Hospital	-12,230,677	2,625,923	121.47
Western Maryland Regional Medical Center	15,201,700	25,261,700	66.18

[32] UM Harford Memorial changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.
[33] UM Upper Chesapeake changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.

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

	2013	2014	
Hospital	**Excess Profit/Loss**	**Excess Profit/Loss**	**% Change in Excess**
All Acute Hospitals[34]	515,138,415	867,825,669	68.46
University of Maryland Medical Center	124,816,000	173,762,036	39.21
Johns Hopkins Hospital	51,063,077	66,850,174	30.92
Sinai Hospital of Baltimore	34,266,918	57,740,993	68.50
Holy Cross Hospital	37,428,046	46,558,000	24.39
Saint Agnes Hospital	41,883,345	44,871,382	7.13
Greater Baltimore Medical Center	33,230,610	40,539,700	22.00
Anne Arundel Medical Center	45,341,200	39,203,200	-13.54
Peninsula Regional Medical Center	10,719,000	29,420,000	174.47
Carroll County General Hospital	30,673,703	27,155,986	-11.47
Northwest Hospital Center	23,613,990	25,618,214	8.49
Western Maryland Regional Medical Center	15,201,700	25,261,700	66.18
MedStar Franklin Square	425,534	21,563,555	4967.41
MedStar Harbor Hospital	6,061,104	20,739,733	242.18
University MIEMSS	18,029,000	20,616,085	14.35
MedStar Union Memorial	-1,472,759	20,389,661	1484.45
UM Upper Chesapeake[35]	22,400,000	19,546,400	N/A
UM Baltimore Washington	-4,380,643	19,474,047	544.55
Meritus Medical Center	9,116,228	18,982,900	108.23
Shady Grove Adventist Hospital	15,263,693	18,326,992	20.07
UM Shore Medical Easton	14,371,024	17,180,916	19.55
Frederick Memorial Hospital	10,738,933	16,993,038	58.24
Suburban Hospital	38,134,858	16,401,687	-56.99
Mercy Medical Center	31,020,207	16,016,399	-48.37
MedStar Saint Mary's Hospital	12,348,616	12,271,586	-0.62
Johns Hopkins Bayview Medical Center	-6,796,000	11,105,000	263.40
Union Hospital of Cecil County	9,281,500	10,810,500	16.47
UM Charles Regional Medical Center	4,734,172	10,169,022	114.80
Howard County General Hospital	19,389,706	9,886,601	-49.01

[34] The All Acute Hospitals line excludes Levindale, UM Harford Memorial, and UM Upper Chesapeake Hospitals.
[35] UM Upper Chesapeake changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.

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

	2013	2014	
Hospital	**Excess Profit/Loss**	**Excess Profit/Loss**	**% Change in Excess**
MedStar Montgomery General	7,262,526	7,075,846	-2.57
Calvert Memorial Hospital	6,916,629	6,802,728	-1.65
Levindale[36]	0	6,801,826	N/A
UM Harford Memorial Hospital[37]	11,524,339	6,704,700	N/A
UM Shore Medical Chestertown	1,065,985	6,550,008	514.46
UM Shore Medical Dorchester	6,630,853	6,224,482	-6.13
Garrett County Memorial Hospital	2,041,070	4,238,955	107.68
MedStar Good Samaritan	-8,126,384	3,971,844	148.88
Bon Secours Hospital	-9,627,191	3,569,505	137.08
Prince Georges' Hospital Center	1,028,098	3,192,390	210.51
UM Midtown	-3,684,386	3,078,202	183.55
Washington Adventist Hospital	-12,230,677	2,625,923	121.47
Bowie Emergency Center	-1,153,106	1,977,798	271.52
McCready Hospital	429,845	1,871,567	335.40
UM Rehabilitation & Orthopedic Institute	-385,298	1,802,113	567.72
Fort Washington Medical Center	576,030	1,380,752	139.70
Atlantic General Hospital	2,725,952	976,248	-64.19
Doctors Community Hospital	-1,415,078	651,801	146.06
Laurel Regional Hospital	-1,570,163	-685,989	56.31
Germantown Emergency Center	-2,264,592	-2,327,154	-2.76
Queen Anne’s Emergency Center	-3,458,234	-3,347,238	3.21
MedStar Southern Maryland	-21,613,758	-5,582,219	74.17
UM Saint Joseph	-72,512,468	-14,131,000	80.51

[36] FY14 is the first year that Levindale was designed as an acute care hospital by CMS.
[37] UM Harford Memorial changed its fiscal year end from December 31 to June 30 in 2014 and therefore has filed a FYE report of 6 months.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§ 19-207, 19-212. and 19-215, Annotated Code of Maryland

NOTICE OF FINAL ACTION

On November 18, 2015, the Health Services Cost Review Commission adopted amendments to Regulation **.02** under **COMAR 10.37.01 "Uniform Accounting and Reporting System for Hospitals and Related Institutions."**

This action, which was proposed for adoption in 42:20 Md. R. 1268 (October 2, 2015), has been adopted as proposed.

Effective Date: November 28, 2015

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

D. — J. (text unchanged)

MARK J. BELTON
Secretary of Natural Resources

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-212, and 19-215, Annotated Code of Maryland

Notice of Proposed Action

[15-264-P-I]

The Health Services Cost Review Commission proposes to amend Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about December 10, 2015.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August, 1987), which has been incorporated by reference.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through November 2, 2015. A public hearing has not been scheduled.

Editor's Note on Incorporation by Reference

Pursuant to State Government Article, §7-207, Annotated Code of Maryland, the Accounting and Budget Manual for Fiscal and Operating Management (August 1987), Supplement 23, has been declared a document generally available to the public and appropriate for incorporation by reference. For this reason, it will not be printed in the Maryland Register or the Code of Maryland Regulations (COMAR). Copies of this document are filed in special public depositories located throughout the State. A list of these depositories was published in 42:1 Md. R. 9 (January 9, 2015), and is available online at www.dsd.state.md.us. The document may also be inspected at the office of the Division of State Documents, 16 Francis Street, Annapolis, Maryland 21401.

.02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The "Accounting and Reporting System for Hospitals", also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a)—(t) (text unchanged)

(u) Supplement 21 (June 5, 2012); [and]

(v) Supplement 22 (March 3, 2014)*; and*

(w) Supplement 23 (July 28, 2015).

(3)—(5) (text unchanged)

B.—D. (text unchanged)

JOHN M. COLMERS
Chairman

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-201 and 19-207, Annotated Code of Maryland

Notice of Proposed Action

[15-262-P]

The Health Services Cost Review Commission proposes to amend Regulation **.07-1** under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about December 10, 2015.

Statement of Purpose

The purpose of this action is to conform COMAR to legislation passed in the 2015 Session of the General Assembly that established that outpatient services associated with the federal 340B Program and that meet certain criteria shall be considered provided "at the hospital" and thereby subject to HSCRC rate jurisdiction.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. Assumption of a moderate benefit to regulated hospitals, third-party payers, and the general public.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-201 and 19-207, Annotated Code of Maryland

NOTICE OF FINAL ACTION

On November 18, 2015, the Health Services Cost Review Commission adopted amendments to Regulation **.07-1** under **COMAR 10.37.10 "Rate Application and Approval Procedure."** This action, which was proposed for adoption in 42:20 Md. R. 1268 - 1269 (October 2, 2015), has been adopted as proposed.

Effective Date: November 28, 2015

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

D. — J. (text unchanged)

MARK J. BELTON
Secretary of Natural Resources

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-212, and 19-215, Annotated Code of Maryland

Notice of Proposed Action

[15-264-P-I]

The Health Services Cost Review Commission proposes to amend Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions.** This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about December 10, 2015.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August, 1987), which has been incorporated by reference.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through November 2, 2015. A public hearing has not been scheduled.

Editor's Note on Incorporation by Reference

Pursuant to State Government Article, §7-207, Annotated Code of Maryland, the Accounting and Budget Manual for Fiscal and Operating Management (August 1987), Supplement 23, has been declared a document generally available to the public and appropriate for incorporation by reference. For this reason, it will not be printed in the Maryland Register or the Code of Maryland Regulations (COMAR). Copies of this document are filed in special public depositories located throughout the State. A list of these depositories was published in 42:1 Md. R. 9 (January 9, 2015), and is available online at www.dsd.state.md.us. The document may also be inspected at the office of the Division of State Documents, 16 Francis Street, Annapolis, Maryland 21401.

.02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The "Accounting and Reporting System for Hospitals", also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a)—(t) (text unchanged)

(u) Supplement 21 (June 5, 2012); [and]

(v) Supplement 22 (March 3, 2014)*; and*

(w) Supplement 23 (July 28, 2015).

(3)—(5) (text unchanged)

B.—D. (text unchanged)

JOHN M. COLMERS
Chairman

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-201 and 19-207, Annotated Code of Maryland

Notice of Proposed Action

[15-262-P]

The Health Services Cost Review Commission proposes to amend Regulation **.07-1** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about December 10, 2015.

Statement of Purpose

The purpose of this action is to conform COMAR to legislation passed in the 2015 Session of the General Assembly that established that outpatient services associated with the federal 340B Program and that meet certain criteria shall be considered provided "at the hospital" and thereby subject to HSCRC rate jurisdiction.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. Assumption of a moderate benefit to regulated hospitals, third-party payers, and the general public.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(+)	Moderate
E. On other industries or trade groups:	(+)	Moderate
F. Direct and indirect effects on public:	(+)	Moderate

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D., E., and F. Assumption of moderate benefit to regulated hospitals, third-party payers and the public is based on hospitals paying less for certain outpatient drugs under the federal 340B Program, which translates to payers and patients paying less as well.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through November 2, 2015. A public hearing has not been scheduled.

.07-1 Outpatient Services — At the Hospital Determination.

A.—B. (text unchanged)

C. In accordance with Health-General Article, § 19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to outpatient services provided at the hospital. *Outpatient services associated with the federal 340B Program under the federal Public Health Service Act provided in a department of a regulated hospital that, on or before June 1, 2015, is under a merged asset hospital system, and which are physically located at another regulated hospital under the same merged asset hospital system, shall be subject to the rate-setting jurisdiction of the Commission.*

D.—J. (text unchanged)

JOHN M. COLMERS
Chairman

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-219, and 19-222, Annotated Code of Maryland

Notice of Proposed Action

[15-263-P]

The Health Services Cost Review Commission proposes to amend Regulation **.10** under **COMAR 10.37.10.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about December 10, 2015.

Statement of Purpose

The purpose of this action is to assure that rate applications are submitted in easily readable formats.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

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.10 Docketing and Receipt.

A. —B. (text unchanged)

C. The hospital shall file an original and three copies of each rate application and its supporting documents, if any. *The Commission may prescribe the format to be used in the submission of rate applications and their supporting documents.* In addition, the hospital shall file with each rate application a certificate of service indicating that the application and supporting documents have been mailed or served upon all designated parties to that proceeding and upon the Commission at its offices.

JOHN M. COLMERS
Chairman

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207, 19-219, and 19-222, Annotated Code of Maryland

NOTICE OF FINAL ACTION

On November 18, 2015, the Health Services Cost Review Commission adopted amendments to Regulation **.10** under **COMAR 10.37.10 "Rate Application and Approval Procedure."** This action, which was proposed for adoption in 42:20 Md. R. 1269 (October 2, 2015), has been adopted as proposed.

Effective Date: November 28, 2015

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(+)	Moderate
E. On other industries or trade groups:	(+)	Moderate
F. Direct and indirect effects on public:	(+)	Moderate

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D., E., and F. Assumption of moderate benefit to regulated hospitals, third-party payers and the public is based on hospital paying less for certain outpatient drugs under the federal 340B Program, which translates to payers and patients paying less as well

Economic Impact on Small Businesses

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Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

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D.—J. (text unchanged)

JOHN M. COLMERS
Chairman

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-219, and 19-222, Annotated Code of Maryland

Notice of Proposed Action

[15-263-P]

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JOHN M. COLMERS
Chairman

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

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Vice-Chairman

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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

Stephen Ports
Principal Deputy Director
Policy and Operations

David Romans
Director
Payment Reform and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **November 18, 2015**

RE: **Hearing and Meeting Schedule**

December 9, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
January 13, 2015	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://www.hscrc.maryland.gov/commission-meetings-2015.cfm

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