maryland
health services
cost review commission

Rate Year 2024 Uncompensated Care Report

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This document contains the staff report for RY 2024 Uncompensated Care Policy. There are no proposed changes in methodology and thus no need for a formal Commission vote at this time.

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Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The purpose of the Uncompensated Care (UCC) policy is to equitably share the financial burden of providing hospital care to patients that are uninsured or underinsured and cannot afford to pay for their care. By including this cost in statewide hospital rates, the HSCRC can ensure that all Marylanders can access care at all hospitals in Maryland.	Funding UCC in the State of Maryland is two fold. 1). Through the UCC markup to hospital rates based on statewide Actual UCC, applied uniformly to acute care hospital rates statewide. For RY 2024, the determined UCC amount to be built into rates for Maryland hospitals is 4.29 percent. 2). Hospital contributions to/from the UCC fund based on a 50/50 blend of Hospital-specific actual UCC and calculated predicted UCC rates.	Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland acute care hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State. For RY 2024, 23 regulated acute care hospitals will pay into the pool while 19 will withdraw from the pool.	UCC is paid by patients and insurers through rates. Therefore, with the incorporation of predicted UCC, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.	The UCC policy represents an underlying historical tenet of health equity in the State, as it ensures that Marylanders, regardless of insurance status, can access care at any hospital and there is no need for public hospitals. All hospitals receive funding from all payers for uncompensated care costs. Hospitals with high volumes of low-income patients are not at a financial disadvantage compared to hospitals with higher income patients, allowing low-income patients to access care at any of the state's hospitals.

INTRODUCTION

The Uncompensated Care Policy was created by the HSCRC to recognize the financial burden borne by hospitals from the continued provision of high quality hospital care to patients who cannot afford to pay for it and to create a financial reimbursement for the provision of

Uncompensated Care (UCC) into the rates the Commission sets for hospitals.[1] The UCC policy is a foundational element of equity built into the all-payer system and continued under the Total Cost of Care Model. The purpose of this report is to provide background on the UCC policy and to provide hospital-specific values for the UCC built into statewide rates as well as the amount of funding that will be made available for the UCC pool, the latter of which ensures the burden of uncompensated care is shared equitably across all hospitals.

Uncompensated Care (UCC) is hospital care provided for which no compensation is received, typically a combination of charity care and bad debt.

Charity Care

Charity care services are "those Commission regulated services rendered for which payment is not anticipated".[2] Charity care is provided to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill. There are two types of charity care that may occur across all payers:

1. **Free care** is care for which the patient is not responsible for any out-of-pocket expenses for hospital care. Hospitals are required statutorily to provide free care to patients with a household income less than 200% of the FPL.[3]
2. **Reduced-cost care** is care for which the patient is only responsible for a portion of out-of-pocket expenses and is required for patients with household income between 200 and 300% of the FPL.[4] Reduced-cost care is also required for patients that have a financial hardship[5] and have household incomes below 500% of the FPL. Financial hardship is defined by statute as medical debt, incurred by a household over a 12-month period, which exceeds 25% of household income.[6] There is no prescribed discount that hospitals must provide to patients between 200% and 500% of the FPL. Per statute "if a patient is eligible for reduced-cost medically necessary care, the hospital shall apply the reduction that is most favorable to the patient."[7]

Bad Debt

The other type of Hospital UCC is bad debt, which is for "Commission regulated services rendered for which payment is anticipated and credit is extended to the patient" but the payment is not made. Unpaid cost shares for patients that do not meet the free thresholds can be charged as bad debt after the hospital makes a reasonable attempt to collect those charges.[8] However,

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[1] Maryland has a unique all-payer rate setting system for hospitals, administered by the HSCRC. Acute general hospitals in Maryland must charge patients (and insurers) the rate set by the HSCRC for health care services.

[2] HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at: https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf

[3] Md. Code, § 19-214.1(b)(2) (i) of the Health General Article

[4] COMAR 10.37.10.26 A-2 (2)(a)(ii)

[5] Md. Code, § 19-214.1(a)(2) of the Health General Article

[6] Md. Code, § 19-214.1(b)(4) of the Health General Article

[7] Md. Code, § 19-214.1(b)(5) of the Health General Article

[8] Bad debt includes unpaid cost share expenses reduced by a reduced-cost care discount for patients eligible for reduced-cost care. The HSCRC requires hospitals to make "a reasonable collection effort" before writing-off bad debt. HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at:

there are several reasons that a hospital may not include bad debts into uncompensated care, most notably denials.[9]

HSCRC's UCC policy assures access to hospital services in the State for those patients who cannot readily pay for them and equitably distributes the burden of uncompensated care costs across all hospitals and all payers. This approach ensures that hospitals with high volumes of low-income patients are not at a financial disadvantage.

For RY 2024, the determined UCC amount to be built into rates for Maryland hospitals is 4.29 percent. Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State.

METHODOLOGY

The UCC methodology is a cornerstone of the HSCRC's all payer system. In addition to equitably supporting financial assistance for low income patients, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.[10]

The HSCRC prospectively calculates the amount of uncompensated care provided in hospital rates at each regulated Maryland hospital using a multi-step process:

1. **Statewide Actual UCC in All-Payer Hospital Rates:** HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percent of gross patient revenue, and is

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https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf

[9] These include: a) Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.; b) Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are not limited to, reductions from established rates for courtesy discounts, employee discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers; c) Charges for medically unnecessary hospital services;). Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort - 08/01/08 SECTION 100 ACCOUNTING PRINCIPLES AND CONCEPTS I

[10] Other states have struggled to maintain sustainable uncompensated care funds. One example is New Jersey. H S Berliner, S Delgado, "The rise and fall of New Jersey's uncompensated care fund", J Am Health Policy. Sep-Oct 1991;1(2):47-50. https://pubmed.ncbi.nlm.nih.gov/10112731/.

applied uniformly to acute care hospital rates statewide. For example, in RY 2024, HSCRC staff will use RY 2022 statewide UCC experience of 4.29 percent to determine the UCC amount built into all hospital rates.

2. **Hospital Payments or Contributions to the UCC Fund**
   The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.

   i. **Hospital-Specific Actual UCC:** HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital[11]. (See Appendix II).

   ii. **Hospital-Specific Predicted UCC:** This step involves use of a logistic regression model to predict UCC. HSCRC allows a 9-month runout period for charity care and bad debt Write-Off reporting. This means hospitals have 9 months from the end of a fiscal year to report charity care and bad debt that occurred in that fiscal year in their Write-Off data submissions to the Commission. HSCRC then uses that amount to predict the UCC amount built into hospital rates for the next fiscal year using area deprivation Index (ADI),[12] payer type, and site of care as independent variables in the logistic regression. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. Incorporating predicted UCC into the methodology provides hospitals with a financial incentive to collect payments so that UCC does not rise too quickly and UCC funds remain available for those who truly need it. Because UCC is paid by patients and insurers through rates, uncontrolled increases in UCC could increase hospital rates for everyone.

   iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature. (See Appendix I).

   iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically,

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[11] Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts

[12] "The Area Deprivation Index ...allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest …. including] factors for...income, education, employment, and housing quality." https://www.neighborhoodatlas.medicine.wisc.edu/

if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

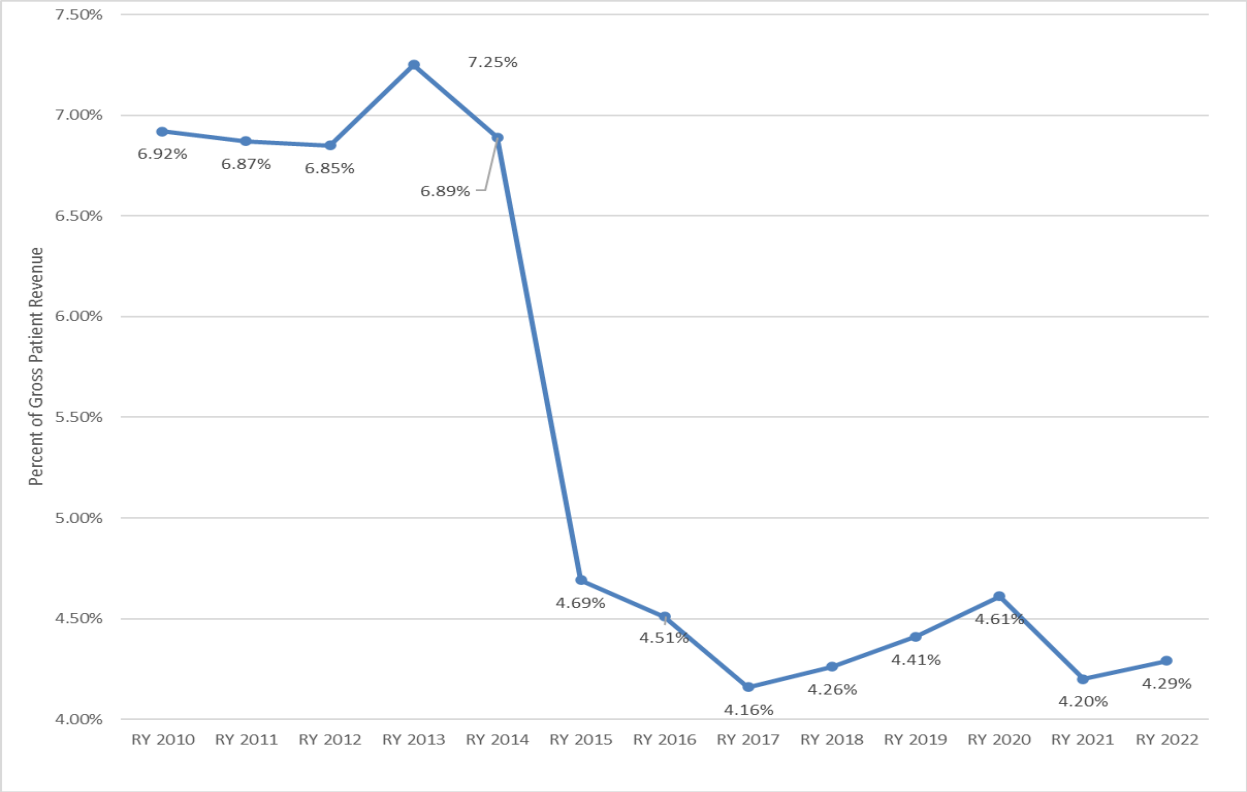
Exhibit 1: UCC Methodology Example ($ Millions)

		Step 1		Step 2 (i)	Step 2 (ii)	Step 2 (iii)	Step 2 (iv)
	A	B	C = A X B	D	E	F = Avg D & E	G = (F-B) X A
	GBR	Prior Year Statewide UCC Rate	UCC Funding Provided in Rates	Prior Year Hospital-Specific UCC Rate	Predicted Hospital-specific UCC Rate	Hospital-Specific 50/50 Blend	(Payment) or Withdrawal from UCC Fund
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

ASSESSMENT

Based on RY 2022 audited reports, the HSCRC has determined that the percentage of UCC to incorporate in hospitals' rates to fund the UCC pool is 4.29 percent, 0.09 percentage points higher than last year's UCC rate of 4.20 percent. The graph below shows the changes in Actual Statewide UCC incorporated in hospital rates since RY 2010. The slight uptick in UCC between RY 2021 and RY 2022 is driven by the increase in Emergency Department (ED) utilization as the COVID-19 Pandemic gradually phased out.

Exhibit 2: Actual Statewide UCC in Rates (RY 2010 – RY 2022)



Additional analyses to understand the downward trend in UCC in RY 2021 showed that the statewide UCC decline that year was driven in part by significant statewide declines in hospital utilization most likely to result in UCC; with declines in ED utilization being the biggest driver. RY 2022 shows a similar trend but in the opposite direction with ED utilization trending upwards (See Exhibit 3 and 4 below). The HSCRC's model to predict UCC is based on the patients' payer type, ADI and site of service, and the probability of a patient subsequently deemed as having UCC is historically highest amongst commercial patients presenting though the ED. Thus, the increase in ED utilization by commercial patients having a write-off to UCC (11 percent) subsequently results in the uptick in UCC and increases the ED utilization's share of total hospital services resulting in UCC.

Exhibit 3: Percent Change from FY18 – FY22 by Site of Service and Payer for Patients with Write-Off to UCC

	CHARITY/SELF PAY				COMMERCIAL				MEDICAID				MEDICARE				OTHER			
Site of Service	% Change FY18-19	% Change FY19-20	% Change FY20-21	% Change FY21-22	% Change FY18-19	% Change FY19-20	% Change FY20-21	% Change FY21-22	% Change FY18-19	% Change FY19-20	% Change FY20-21	% Change FY21-22	% Change FY18-19	% Change FY19-20	% Change FY20-21	% Change FY21-22	% Change FY18-19	% Change FY19-20	% Change FY20-21	% Change FY21-22
ED	8%	-10%	-42%	-1%	-9%	-21%	-52%	11%	10%	-9%	-32%	14%	-5%	-18%	-35%	-3%	7%	-9%	-64%	6%
IP	35%	3%	-12%	-18%	-7%	-12%	-25%	0%	1%	4%	-46%	17%	-1%	-2%	-26%	2%	13%	1%	-31%	-8%
OP	33%	-2%	-12%	3%	-8%	-22%	-20%	7%	14%	-26%	-19%	9%	-11%	-21%	-27%	2%	-31%	-6%	-42%	-26%
Total	**17%**	**-7%**	**-30%**	**-1%**	**-8%**	**-20%**	**-35%**	**8%**	**9%**	**-10%**	**-32%**	**14%**	**-7%**	**-17%**	**-30%**	**1%**	**-5%**	**-7%**	**-53%**	**-5%**

Exhibit 4: Site of Service Shares for Patients with Write-Off to UCC

Site of Service	RY 2018	RY 2019	RY 2020	RY 2021	RY 2022
ED	54.3%	54.5%	54.4%	50.2%	50.9%
IP	8.6%	8.8%	9.6%	10.2%	9.8%
OP	37.1%	36.8%	36.0%	39.6%	39.3%

IMPLEMENTATION

Based on the preceding analysis, HSCRC staff will implement the following for RY 2024:

1. Increase the statewide UCC provision in rates from 4.20% to 4.29% effective July 1, 2023.
2. Continue to use the regression modeling approach previously approved by the Commission.
3. Continue to apply a 50/50 blend of RY2022 audited UCC levels and RY2022 predicted UCC levels to determine hospital-specific adjustments for the UCC Fund.

COVID-19 IMPLICATIONS

With the protections put in place by the state during the pandemic to ensure coverage and patient access to care most notably the suspension of Medicaid Eligibility Redeterminations, big declines in UCC in RY 2021 caused staff to predict similar trends for RY 2022 and RY 2023. However, this has not proven to be the case as UCC in RY 2022 showed a slight incline. In keeping with staff promise, future iterations of the UCC policy will provide an enhanced UCC markup in rates in line with the most recent UCC actual, as per the design of the policy.

In CY 2020, Staff began evaluating the possibility of using multi-year actual UCC averages in lieu of the one-year figures to do the 50/50 blend with predicted UCC from the regression. Staff believes that using two or more years of history will make the statistic more stable, especially as the declining trends due to the implementation of the Affordable Care Act appear to have dissipated. Staff also believes that the use of multi-year averages will help control for anomalies such as the effects of Covid-19 on hospital Utilization. Staff, however, have halted further work on this and other policy development to allow the hospitals sufficient bandwidth to respond to the pandemic. Staff plans to resume evaluation of the multi-year blend on actuals for the RY 2025 UCC policy.

Appendix I. Hospital Uncompensated Care Provision for RY 2024

HOSPID	HOSPNAME	FY2023 GBR Permanent Revenue	FY 2022 UCC Based on FY 2023 GBR Permanent Revenue	FY 2022 Percent UCC from the RE Schedule	Percent Predicted UCC (Adjusted)	Predicted UCC Amounts (Based on FY 2023 GBR Permanent Revenue)	50/50 Blend Percent	50/50 Blend Adjusted to FY 2022 UCC Based on FY 2023 GBR Permanent Revenue Level	Percent UCC
210001	Meritus Medical Cntr	$443,254,882	$ 20,339,157	4.59%	4.66%	$ 20,665,404	4.63%	$ 22,956,081	5.18%
210002	UMMC	$1,871,729,866	$ 73,036,719	3.90%	2.76%	$ 51,743,580	3.33%	$ 69,857,269	3.73%
210003	UM-Prince George's Hospital	$389,829,607	$ 57,441,972	14.74%	4.49%	$ 17,518,548	9.61%	$ 41,966,058	10.77%
210004	Holy Cross	$590,003,012	$ 43,984,177	7.45%	5.56%	$ 32,820,831	6.51%	$ 42,998,680	7.29%
210005	Frederick Memorial	$420,197,912	$ 17,190,531	4.09%	3.39%	$ 14,264,262	3.74%	$ 17,609,718	4.19%
210006	UM-Harford Memorial	$120,311,054	$ 7,873,582	6.54%	3.14%	$ 3,781,579	4.84%	$ 6,525,050	5.42%
210008	Mercy Medical Cntr	$663,352,288	$ 25,450,568	3.84%	3.63%	$ 24,068,098	3.73%	$ 27,722,635	4.18%
210009	Johns Hopkins	$2,957,738,749	$ 77,730,530	2.63%	2.91%	$ 86,016,797	2.77%	$ 91,672,653	3.10%
210011	St. Agnes Hospital	$497,538,190	$ 27,052,210	5.44%	6.05%	$ 30,078,966	5.74%	$ 31,984,439	6.43%
210012	Sinai Hospital	$958,198,246	$ 26,070,562	2.72%	3.05%	$ 29,203,307	2.88%	$ 30,944,641	3.23%
210015	MedStar Franklin Square	$647,560,823	$ 25,818,261	3.99%	3.40%	$ 21,992,525	3.69%	$ 26,766,492	4.13%
210016	Washington Adventist Hospital	$357,809,663	$ 30,180,030	8.43%	3.48%	$ 12,465,815	5.96%	$ 23,874,941	6.67%
210017	Garrett Co Memorial	$79,922,950	$ 5,181,330	6.48%	7.09%	$ 5,664,608	6.79%	$ 6,072,013	7.60%
210018	MedStar Montgomery	$209,894,309	$ 8,416,185	4.01%	2.11%	$ 4,422,445	3.06%	$ 7,187,606	3.42%
210019	Peninsula Regional	$552,977,901	$ 20,655,424	3.74%	4.66%	$ 25,776,298	4.01%	$ 25,994,434	4.70%
210022	Suburban	$411,802,792	$ 14,504,425	3.52%	2.19%	$ 9,037,578	2.86%	$ 13,179,805	3.20%
210023	Anne Arundel Medical Cntr	$755,006,222	$ 20,965,778	2.78%	1.95%	$ 14,755,985	2.37%	$ 19,998,548	2.65%
210024	MedStar Union Memorial	$494,548,330	$ 15,983,580	3.23%	4.06%	$ 20,078,570	3.65%	$ 20,189,111	4.08%
210027	Western Maryland	$378,607,391	$ 17,521,220	4.63%	6.55%	$ 24,811,894	5.59%	$ 23,699,861	6.26%
210028	MedStar St. Mary's	$219,437,635	$ 7,194,962	3.28%	2.18%	$ 4,784,210	2.73%	$ 6,706,445	3.06%

210029	JH Bayview	$801,672,789	$ 37,148,957	4.63%	5.03%	$ 40,315,068	4.83%	$ 43,367,625	5.41%
210030	UM-SRH at Chestertown	$57,698,993	$ 3,871,978	6.71%	3.85%	$ 2,219,963	5.28%	$ 3,410,525	5.91%
210032	Union Hospital of Cecil Co	$193,877,039	$ 9,638,733	4.97%	2.54%	$ 4,918,870	3.75%	$ 8,149,959	4.20%
210033	Carroll Co Hospital Cntr	$268,940,103	$ 7,235,586	2.69%	1.94%	$ 5,204,436	2.31%	$ 6,964,448	2.59%
210034	MedStar Harbor Hospital Cntr	$214,544,707	$ 10,311,515	4.81%	5.21%	$ 11,185,746	5.01%	$ 12,035,072	5.61%
210035	UM-Charles Regional	$183,549,950	$ 11,632,653	6.34%	3.71%	$ 6,811,553	5.02%	$ 10,325,844	5.63%
210037	UM-SRH at Easton	$282,250,183	$ 11,344,702	4.02%	2.52%	$ 7,114,077	3.27%	$ 10,334,002	3.66%
210038	UMMC - Midtown	$268,995,697	$ 14,782,063	5.50%	4.09%	$ 11,013,046	4.79%	$ 14,441,189	5.37%
210039	Calvert Health Med Cntr	$178,132,879	$ 4,435,539	2.49%	2.05%	$ 3,647,192	2.27%	$ 4,525,053	2.54%
210040	Northwest Hospital Cntr	$308,413,899	$ 10,194,088	3.31%	2.76%	$ 8,506,532	3.03%	$ 10,469,395	3.39%
210043	UM-BWMC	$516,228,839	$ 25,663,098	4.97%	2.27%	$ 11,695,650	3.62%	$ 20,915,001	4.05%
210044	GBMC	$498,538,569	$ 9,195,059	1.84%	2.37%	$ 11,811,895	2.11%	$ 11,760,578	2.36%
210048	Howard County General	$360,257,158	$ 13,285,496	3.69%	2.71%	$ 9,779,672	3.20%	$ 12,912,853	3.58%
210049	UM-Upper Chesapeake	$373,198,865	$ 18,787,835	5.03%	2.01%	$ 7,507,687	3.52%	$ 14,721,341	3.94%
210051	Doctors Community	$299,866,966	$ 19,356,399	6.45%	5.05%	$ 15,144,009	5.75%	$ 19,314,782	6.44%
210056	MedStar Good Samaritan	$311,475,369	$ 12,836,652	4.12%	4.37%	$ 13,605,454	4.24%	$ 14,803,405	4.75%
210057	Shady Grove Adventist Hospital	$522,556,831	$ 32,281,665	6.18%	3.04%	$ 15,889,677	4.61%	$ 26,968,347	5.16%
210060	Fort Washington Medical Center	$67,020,261	$ 4,718,044	7.04%	4.73%	$ 3,170,255	5.89%	$ 4,416,202	6.59%
210061	Atlantic General	$127,713,601	$ 3,510,528	2.75%	3.77%	$ 4,815,582	3.26%	$ 4,661,307	3.65%
210062	MedStar Southern MD	$321,465,864	$ 13,544,525	4.21%	2.75%	$ 8,843,101	3.48%	$ 12,533,536	3.90%
210063	UM-St. Joseph Med Cntr	$466,947,045	$ 17,258,104	3.70%	2.19%	$ 10,219,139	2.94%	$ 15,382,918	3.29%
210065	HC-Germantown	$141,990,525	$ 8,181,418	5.76%	5.08%	$ 7,213,494	5.42%	$ 8,618,721	6.07%
Statewide	**Total**	**$ 19,785,057,957**	**$ 841,805,838**	**4.29%**	**3.40%**	**$ 674,583,396**	**3.83%**	**$ 848,938,585**	**4.29%**

Appendix II. Actual UCC Summary Statistics

The table below shows the Actual UCC Statewide and by hospital between RY 2022 and RY 2021– it does not reflect predicted UCC rates.

HOSPID	HOSPNAME	RY2022 % UCC	RY2021 % UCC	Variance Over/Under
210001	Meritus Medical Cntr	4.59%	4.98%	**-0.39%**
210002	UMMC	3.90%	3.85%	**0.05%**
210003	UM-Prince George's Hospital	14.74%	10.51%	**4.23%**
210004	Holy Cross	7.45%	6.97%	**0.48%**
210005	Frederick Memorial	4.09%	4.22%	**-0.13%**
210006	UM-Harford Memorial	6.54%	6.43%	**0.12%**
210008	Mercy Medical Cntr	3.84%	4.68%	**-0.84%**
210009	Johns Hopkins	2.63%	2.33%	**0.30%**
210011	St. Agnes Hospital	5.44%	4.40%	**1.04%**
210012	Sinai Hospital	2.72%	3.30%	**-0.58%**
210015	MedStar Franklin Square	3.99%	3.29%	**0.70%**
210016	Washington Adventist	8.43%	7.55%	**0.89%**
210017	Garrett Co Memorial	6.48%	6.13%	**0.36%**
210018	MedStar Montgomery	4.01%	3.94%	**0.07%**
210019	Peninsula Regional	3.74%	3.60%	**0.13%**
210022	Suburban	3.52%	3.80%	**-0.28%**
210023	Anne Arundel Medical Cntr	2.78%	2.56%	**0.22%**
210024	MedStar Union Memorial	3.23%	3.01%	**0.22%**
210027	Western Maryland	4.63%	4.45%	**0.18%**
210028	MedStar St. Mary's	3.28%	2.95%	**0.32%**
210029	JH Bayview	4.63%	4.49%	**0.14%**
210030	UM-SRH at Chestertown	6.71%	5.91%	**0.80%**
210032	Union Hospital of Cecil Co	4.97%	6.52%	**-1.55%**
210033	Carroll Co Hospital Cntr	2.69%	3.20%	**-0.51%**
210034	MedStar Harbor Hospital Cntr	4.81%	3.93%	**0.88%**
210035	UM-Charles Regional	6.34%	6.06%	**0.27%**
210037	UM-SRH at Easton	4.02%	3.74%	**0.28%**
210038	UMMC - Midtown	5.50%	5.05%	**0.44%**
210039	Calvert Health Med Cntr	2.49%	2.51%	**-0.02%**
210040	Northwest Hospital Cntr	3.31%	5.14%	**-1.83%**
210043	UM-BWMC	4.97%	5.47%	**-0.50%**
210044	GBMC	1.84%	3.24%	**-1.40%**
210048	Howard County General	3.69%	4.42%	**-0.73%**
210049	UM-Upper Chesapeake	5.03%	5.65%	**-0.62%**
210051	Doctors Community	6.45%	4.71%	**1.74%**
210056	MedStar Good Samaritan	4.12%	3.89%	**0.23%**

210057	Shady Grove	6.18%	6.26%	**-0.09%**
210058	UM-ROI	3.78%	3.70%	**0.08%**
210060	FT. Washington	7.04%	7.36%	**-0.32%**
210061	Atlantic General	2.75%	3.75%	**-1.00%**
210062	MedStar Southern MD	4.21%	4.51%	**-0.30%**
210063	UM-St. Joseph Med Cntr	3.70%	3.70%	**0.00%**
210064	Levindale	5.11%	6.10%	**-0.99%**
210065	HC-Germantown	5.76%	6.69%	**-0.93%**
218992	UM-Shock Trauma	6.34%	6.20%	**0.14%**
	Total	**4.29%**	**4.20%**	**0.09%**

Note: Free-Standing EDs and/or Medical Centers, Behavior Health and Specialty Hospitals are not included in this analysis
Source: HSCRC RE Schedules