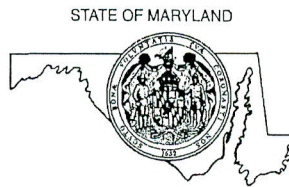


Craig Tanio, M.D.
CHAIR



Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

February 3, 2015

The Honorable Lawrence J. Hogan, Jr.
Governor
State of Maryland
100 State Circle
Annapolis, MD 21401-1991

The Honorable Thomas V. Michael Miller
President of the Senate
State House, H-107
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House of Delegates
State House, H-101
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
State House, H-107
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair
Health and Government Operations Committee
State House, H-101
Annapolis, MD 21401-1991

RE: Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities – *Maryland Health Care Commission*, Chapters 505 & 506, 699, S.B. 593/H.B. 699 (2010 Regular Session)

Dear Governor Hogan, President Miller, Speaker Busch, Chairman Middleton, and Chairman Hammen:

The Maryland Health Care Commission (Commission or MHCC) is pleased to submit the enclosed "Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities," as required under Chapters 505 & 506 of Senate Bill 593/House Bill 699 (2010 Regular Session). The law required the Commission, in consultation with the Health Services Cost Review Commission (HSCRC) to conduct a study of the effect of the rates established for freestanding medical facility (FMF) pilot projects by the Health Services Cost Review Commission under § 19–211(c) of the Health – General Article. In addition, the Commission is required, based on the conclusions and recommendations in this report, to propose regulations for the review of applications for Certificates of Need (CON) to establish freestanding medical facilities.

The enclosed report includes an overview of Maryland and national trends in emergency department utilization, analysis of the impact of HSCRC rate setting on the financial performance of Germantown Emergency Center, comparative information on the three Maryland FMFs, and conclusions and recommendations regarding the development of CON regulations for freestanding medical facilities.

Emergency department utilization increased in Maryland between 2000 and 2011, consistent with national trends for this period. In response to the growing number of emergency department visits, hospitals re-engineered their emergency departments, and in some cases, FMFs were established to reduce the

pressure on hospitals' emergency departments. In Maryland, Germantown Emergency Center (GEC) was established in August 2006 to alleviate overcrowding at Shady Grove Adventist Hospital. However, Queen Anne's Emergency Center (QAEC) was established in October 2010 for another reason, the need to increase access to emergency services in Queen Anne's County given the distance to hospital emergency departments, traffic congestion, and the periodic closure of the Bay Bridge. Bowie Health Center (BHC) was established in 1979 as a satellite center with the initial expectation that it would evolve into a full-service hospital. However, it continues to operate as an FMF.

The Germantown Emergency Center is the only freestanding medical facility that has operated both before and after HSCRC began regulating rates for freestanding medical facilities on July 1, 2011. The Queen Anne's Emergency Medical Center has only operated as a rate-regulated FMF, and Bowie Health Center also has only operated as a rate regulated facility, although the manner in which it has been rate regulated has changed. The financial performance of Germantown Emergency Center suggests that rate setting by HSCRC was not clearly advantageous or disadvantageous because the range of net revenue generated before and after rate setting appears similar.

In comparing Maryland's freestanding medical facilities to each other and their affiliated hospitals, MHCC notes that the patient population using FMFs is admitted for inpatient hospital care at a substantially lower rate than the patient population presenting at hospitals' emergency departments. In FY 2014, the average rate of admission at Maryland FMFs was 4.5% compared to a statewide average of 14.8% for emergency departments at Maryland hospitals. In addition, the vast majority of patient visits at FMFs occurred during hours when a viable alternative for treating urgent minor problems may be available for some patients. In FY 2014, overnight use, defined as patient registration between midnight and 8am, was only 9% of total visits at QAEC, 12% at BHC, and 21% at GEC.

In order to be successful in moderating the demand for costly emergency department use, especially by lower acuity patients, Maryland must continue to support the development of integrated care models that can reduce costs for the health care system, while meeting the needs of the population. FMFs may be a more costly vehicle for expanding access and availability of emergency medical care when a combination of general hospital ED facilities and lower cost urgent care centers are available nearby.

The pilot facility experience suggests that the way in which the need for freestanding medical facilities is defined by their hospital sponsors will vary depending on the particular market conditions where FMFs are proposed. In suburban and exurban areas of the State where travel time issues related to traffic congestion are of paramount concern, there will often be overlapping service areas with multiple alternative hospital EDs. When multiple hospital EDs could potentially meet a population's need for emergency medical services, the rationale for developing an FMF to handle many patients with non-urgent or moderately acute medical problems is dubious. In rural areas of the State, the development of an FMF is likely to provide the greatest improvement in access to emergency medical care. However, in a rural area, an FMF has the least chance of becoming self-sustaining because of its small operating base.

In developing new regulatory policies and standards, it will be important for MHCC to require a hospital to explain why the extension of mostly urgent and some emergent medical care beyond the hospital's ED cannot be better accomplished with less expensive models of unscheduled care delivery. MHCC should require a hospital to justify the development of an FMF by showing that it will serve as a resource that improves the health status of the population in its likely service area.

Please do not hesitate to contact me at (410) 764-3566 if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Ben Steffen", with a long horizontal flourish extending to the right.

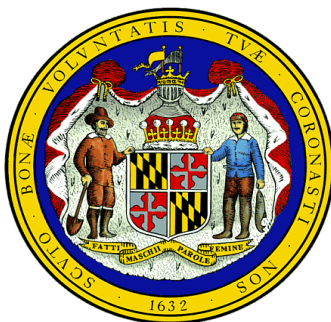
Ben Steffen
Executive Director

Enclosure

cc: Honorable Van T. Mitchell, Secretary, DHMH
Sarah Albert, DLS Library
Patrick Carlson, Senate Finance Committee
Linda Stahr, HGO Committee



Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities



February 4, 2015

Craig Tanio, M.D.
Chair

Ben Steffen
Executive Director

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I. INTRODUCTION

Background

Over the last two decades, Maryland hospitals, like hospitals throughout the nation, experienced increasing emergency department (ED) utilization. This increased use has included services for non-urgent as well as urgent medical problems. Increasing utilization has resulted in ED overcrowding, decreasing access to emergency care, and increasing health care expenditures because of the high cost of ED services. In attempting to address this problem, Maryland hospitals expanded ED service capacity but also gave attention to operational improvements, to increased rates of patient “throughput” per resource unit in the ED, and to the development of alternative models to improve access to urgent and emergency care. Several Maryland hospitals developed or partnered with other organizations to develop urgent care centers in their service areas. These urgent care centers offer extended hours, walk-in appointments, and treatment for minor illnesses and injuries. Another model that has been developed in Maryland is the hospital-affiliated, freestanding medical facility. These facilities, licensed as freestanding medical facilities (FMF), are frequently described as “freestanding emergency centers.” Freestanding medical facilities, similar to hospital emergency departments, provide services 24 hours a day, seven days a week, and provide stabilizing treatment to a patient presenting with an emergency medical condition, regardless of the patient’s specific medical condition, insurance status, or ability to pay. The staffing, equipment, and services available are similar to those available in hospital emergency departments. A copy of the licensure standards that freestanding medical facilities must maintain is included in Appendix 1. In contrast to freestanding medical facilities, the regulatory oversight for urgent care centers is less stringent. In Maryland, urgent care centers are not licensed health care facilities. Urgent care centers are viewed as physician office settings, and direct regulation is limited to the health care professionals that work in them. Additional regulations may be applicable if an urgent care center has radiological equipment or provides laboratory testing.

Legislation¹ enacted by the Maryland General Assembly in 2010 requires the Maryland Health Care Commission (the Commission or MHCC), in consultation with the Health Services Cost Review Commission (HSCRC), to conduct a study of the operations, utilization, and financing of freestanding medical facilities, using information collected from two pilot project sites: the Germantown Emergency Center, which opened in 2006, and the Queen Anne’s Emergency Center, which opened in 2010. Information about a third site that was subsequently licensed as a freestanding medical facility, the Bowie Health Center, is also included in this report. In addition, the Commission, in consultation with the Department of Health and Mental Hygiene and HSCRC, is also required, based on the conclusions and recommendations in this report, to propose regulations for the review of applications for Certificates of Need to establish freestanding medical facilities. (Appendix 2 provides a timeline that shows key activities in the evolution of the Freestanding Medical Facilities Pilot Project. A copy of the law is provided in Appendix 3.)

¹ Chapters 505 and 506 of the 2010 Laws of Maryland – Freestanding Medical Facilities – Rates. The 2010 law modified the law adopted in 2005 and amended in 2007, codified in various sections of the Health-General Article of Maryland Code Annotated, which authorized the initial freestanding medical facility pilot project. A copy of the law is provided in Appendix 3.

FMFs are allowed under the Centers for Medicare and Medicaid Services (CMS) Medicare/Medicaid conditions of participation (CoP) as described in 42 CFR 482.1 through 482.57. FMFs are subject to the same requirements as their parent hospitals' EDs, including 24-hour per day operation and EMTALA² obligations. Both EMTALA and Medicare Conditions of Participation apply to FMFs.

In June 2014, the Board of Directors of the American College of Emergency Physicians (ACEP) issued a policy statement on freestanding emergency departments, the term often used to describe freestanding medical facilities.³ The ACEP stated that any emergency center⁴ that presents itself as an ED, regardless of whether it is a hospital owned or independently owned, should:

- Be available to the public 24 hours a day, seven days a week, 365 days per year.
- Be staffed by appropriately qualified emergency physicians.
- Have adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.
- Be staffed at all times by a registered nurse (RN) with a minimum requirement of current certification in advanced cardiac life support and pediatric advanced life support.
- Have policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed (ie, cath labs, surgery, ICU).

The ACEP statement reflects the proliferation of these facilities. A 2014 article in the Journal for Freestanding Emergency Medicine, a journal recently established to further growth of emergency centers, reported that there were approximately 400 emergency centers in 16 different states.⁵ The growth of emergency centers can be linked to hospitals' desire to expand into communities that are underserved by hospital EDs, generate admissions to their hospital and reduce crowding at their hospital EDs.

Many of the concerns about freestanding medical facilities have centered on the cost of patient care in this setting. When an individual obtains medical care at a freestanding medical facility that could have been obtained in a physician's office or urgent care center, an insurer pays more for the patient's medical care because it must pay a facility charge and a professional charge for services. If the patient had obtained medical care in an office-based setting, such as a physician's office or urgent care center, there would only be a bill for professional services. Thus, treating patients with non-urgent medical problems in an office based setting is more cost-

² The Emergency Medical Treatment & Labor Act (EMTALA), enacted in 1986, ensures public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer is implemented.

³ Referenced at <http://www.acep.org/Clinical---Practice-Management/Freestanding-Emergency-Departments/>

⁴ Although the American College of Emergency Physicians and other sources used the term "emergency departments," this report will use the term "emergency centers" to avoid confusion with hospital emergency departments, consistent with Maryland law and regulations

⁵ <http://www.jfsem.org/this-article.php?a=47&category=Issues&subCategory=>

effective than a freestanding medical facility. While patients generally have higher co-payments for emergency services, which may be seen as a deterrent to using hospital emergency departments or freestanding medical facilities for non-urgent care, it is likely that it is often not significantly high enough to offset the convenience of a freestanding medical facility, which often has shorter wait times than a hospital emergency department and is always open, unlike an urgent care center.

The purpose of this Report is to:

1. Provide an updated review of Maryland and national trends in ED utilization.
2. Report on the effect of the rates established for the freestanding medical facility pilot projects on the cost of health care in Maryland.
3. Compare the operations, utilization, and financing of the freestanding medical facility pilot sites in Maryland.
4. Reach conclusions regarding FMF operations, use, and financial performance, and make appropriate recommendations.

Organization of the Report

This report is organized into the following major sections:

- Overview: Maryland and National Trends in Emergency Department Utilization. This section of the report provides an overview of Maryland and national usage of hospital emergency departments, urgent care centers, and freestanding emergency centers
- Description of Freestanding Medical Facility Pilot Projects. This section describes each of the two pilot projects, the Germantown Emergency Center and the Queen Anne's Emergency Center, and also the Bowie Health Center, which was established in 1979 and subsequently licensed as an FMF.
- Impact of Rate Regulation. This section describes the financial performance of the Germantown Emergency Center before and after it became rate regulated.
- Comparison of Freestanding Medical Facilities. This section compares the three FMFs and discusses the differences among the FMFs.
- Conclusions and Recommendations. This section highlights key findings from the two freestanding medical facility pilot projects and evaluates the impact of the freestanding medical facilities on their affiliated hospitals' emergency departments (Adventist HealthCare Shady Grove Medical Center, University of Maryland Shore Medical Center at Easton, and the Prince George's Hospital Center). It also includes recommendations regarding the development of CON regulations for FMFs.

About the Maryland Health Care Commission

The Maryland Health Care Commission is a 15-member, independent regulatory commission, functioning administratively within the Department of Health and Mental Hygiene. The 15 Commissioners are appointed by the Governor with the advice and consent of the Maryland Senate. The Maryland General Assembly created the Commission in 1999 through the consolidation of two existing commissions to “establish a streamlined health care regulatory system within the State of Maryland in a manner such that a single State health policy can be better articulated, coordinated, and implemented in order to better serve the citizens of this State.” The Commission staff is organized around four centers: the Center for Health Care Facilities and Planning and Development; the Center for Quality Measures and Reporting; the Center for Analysis and Information Systems; and the Center for Health Information Technology and Innovative Care Delivery. The Center for Health Care Facilities Planning and Development is responsible for: developing the State Health Plan; administering the Certificate of Need, Certificates of Conformance, and Certificates of Ongoing Performance programs; and collecting information on health care facility capacity and use. This report was prepared by the Center for Health Care Facilities Planning and Development.

II. Overview: Maryland and National Trends in Emergency Department Utilization

Trends in Maryland Hospital Emergency Department Utilization

Visits to Maryland hospital emergency departments reached an all-time high, topping 2.6 million, in FY 2012. Visit volume has moderated in the two fiscal years that have closed since that peak. Statewide, visits to Maryland emergency departments grew by more than 33 percent, from 1.84 million to 2.6 million during the period 2000 to 2013 (Table 1).

After increasing at an annual rate of less than one percent in the first half of the 1990's, emergency department visits grew by an average of 2.7 percent annually between 1995 and 1999. The average annual increase in emergency department visit volume accelerated over the period 2000 to 2004 with visits growing at an average annual rate of 4.4 percent. In a 2002 report prepared by their Joint Work Group on Emergency Department Utilization, the MHCC and the HSCRC identified factors that contributed to the rapid increase in ED use in Maryland including: an increased use of the ED for non-emergent care; a lack of public understanding about the appropriate use of emergency services; increased use of ED services by managed care enrollees; and, the lack of access to primary care physicians⁶.

The volume of ED visits continued to grow in Maryland between 2005 and 2012; however, the rate of growth slowed to an average of 2.3 percent annually. Maryland ED visits declined slightly in FY 2013 and by four percent from FY 2013 to FY 2014. In comparing this most recent fiscal year with the peak year of 2012, there were fewer ED visits by patients in the younger age groups (0-5 years, 6-15 years, and 16-25 years of age). There were similar proportions of working age adults (26-65 years of age), and a slightly higher percentage of patients over age 65 during this time period (20.9% in 2012 and 22.3% in 2014).

Hospital Emergency Department Treatment Capacity

On an average daily basis, statewide emergency department visit volume increased from about 4,300 visits in FY 1995 to 7,100 visits in FY 2013. All but one of the 47 licensed general hospitals in Maryland operates an emergency department.⁷ While five general acute care hospitals closed in Maryland during the 1990's, no hospital closures have occurred since 2000.⁸ Atlantic General Hospital, located in Worcester County on the Eastern Shore, opened in 1993. Two hospitals in Cumberland, Allegany County, were replaced by a single hospital, Western Maryland Regional, in 2010. A new general hospital, Holy Cross Germantown Hospital, opened in October 2014. While the number of acute care hospitals in Maryland has remained fairly

⁶ Maryland Health Care Commission and the Health Services Cost Review Commission (2002). Trends in Maryland Hospital Emergency Department Utilization: An Analysis of Issues and Recommended Strategies to Address Crowding.

⁷ The University of Maryland Rehabilitation and Orthopaedic Institute, formerly known as James Lawrence Kernan Hospital, is licensed as a general hospital but primarily functions as a special hospital for acute rehabilitation and chronic care. It does not operate an emergency department.

⁸ Closures include three hospitals in Baltimore City: North Charles Hospital (1991); Liberty Medical Center (1999); and Church Hospital (1999). Children's Hospital in Baltimore City, which closed in 1999, did not offer emergency department services. The remaining two hospitals were located in Prince George's County (Leland Memorial Hospital-1993) and Allegany County (Frostburg Community Hospital-1995).

stable since 2000, licensed acute care hospital bed capacity went through a period of growth (14%) in response to higher patient census levels between 2001 and 2009, but bed capacity began a steady decline after 2009. It declined by about 10% between 2009 and 2014, from 10,880 beds to 9,804 beds. At the same time, the treatment capacity of Maryland emergency departments has grown. Treatment spaces in hospital emergency departments increased by more than 40 percent between 2003 and 2013, from 1,472 to 2,101. Over this same time period, the number of hospitals with 50 or more treatment spaces in their emergency departments nearly tripled, from six to 17 hospitals. With increases in emergency department treatment capacity, the average annual number of visits per treatment space statewide declined slightly between 2003 and 2013, from 1,394 to 1,234, despite increases in visits.

Table 1
Total Emergency Department Visits: Fiscal Years 1995-2014

Fiscal Year	Hospital ED Visits	Change		Average Daily ED Visits
		Number	Percent	
1995	1,583,624	53,171	3.5%	4,339
1996	1,587,149	3,525	0.2%	4,336
1997	1,624,121	36,972	2.3%	4,450
1998	1,631,416	7,295	0.4%	4,470
1999	1,747,981	116,565	7.1%	4,789
2000	1,839,205	91,224	5.2%	5,025
2001	1,937,838	98,633	5.4%	5,309
2002	2,027,006	89,168	4.6%	5,553
2003	2,052,442	25,436	1.3%	5,623
2004	2,165,262	112,819	5.5%	5,916
2005	2,199,355	34,094	1.6%	6,026
2006	2,259,004	59,649	2.7%	6,189
2007	2,297,015	38,011	1.7%	6,293
2008	2,378,151	81,136	3.5%	6,498
2009	2,458,894	80,743	3.4%	6,737
2010	2,471,662	12,768	0.5%	6,772
2011	2,505,660	33,998	1.3%	6,865
2012	2,605,182	99,522	3.8%	7,137
2013	2,593,550	-11,632	-0.4%	7,106
2014	2,480,669	-112,881	-4.5%	6,796

Source: Maryland Health Care Commission (Data reported is from the HSCRC Financial Data Base for fiscal years 1995-2014).

How Maryland Compares with the United States

The pattern of increasing emergency department utilization experienced in Maryland between 2000 and 2011 is consistent with national data. According to the American Hospital Association, the number of emergency department visits to U.S. hospitals increased by 22 percent between 2000 and 2010.⁹ Data from the 2011 National Hospital Ambulatory Medical

⁹ American Hospital Association (2012). Prepared to care: The 24/7 Standby Role of America's Hospitals. November 2012.

Care Survey reported by the U.S. Centers for Disease Control and Prevention (CDC) shows that the growth in emergency department visits nationwide has continued with approximately 136 million¹⁰ emergency department visits to community hospitals in 2011 compared with 117 million in 2008.¹¹ Data reported by the American Hospital Association for 2012 shows considerable variation in the use of emergency department services across the United States. Maryland's rate of utilization, at 434 visits per 1,000 population, is higher than the U.S. rate of 424 per 1,000 population. The District of Columbia has the highest ED use rate (788 visits per 1,000 population), and Hawaii has the lowest use rate (287 per 1,000 population).¹²

According to a 2014 report by the American College of Emergency Physicians (ACEP),¹³ emergency departments in Maryland remain overcrowded with one of the longest median wait times in the nation. The average wait time from time of arrival to hospital admission was reported to be 367 minutes (or 6.1 hours) in Maryland hospital EDs, as compared with the U.S. average of 272 minutes. The median wait time in Maryland hospital EDs has increased by two hours since 2006. Median wait times in some neighboring states are shorter than Maryland's (Virginia 286 minutes; Pennsylvania 275 minutes). However, the median wait time in the District of Columbia is approximately an hour and a half longer than in Maryland (452 minutes). Although Maryland ranked number one compared to other states in terms of care quality and patient safety environment, Maryland did not rank as high with respect to access to emergency care, including access to treatment centers, providers, and specialists (23rd in the U.S.). The ACEP reports that poor access to care in Maryland is partially due to few emergency departments per capita; Maryland has 8.3 emergency departments per million people compared with the U.S. average of 18.9 per million people. In a state report card developed by ACEP, Maryland was given a C grade for its overall emergency medical care, which was a decrease from its previous grade of B-.

MHCC reports median emergency department wait times for admitted patients from time of arrival in the ED to departure to a hospital bed in the Hospital Quality section of its web-based [Maryland Health Care Quality Reports](#).¹⁴ For 2013, median wait times from arrival to admission ranged from 207 minutes at Atlantic General to 639 minutes at the [University of Maryland Medical Center](#). Both academic medical centers had wait times well over 500 minutes. The statewide median was 370 minutes compared to 274 minutes for the US. Wait time at Shady Grove was 402 minutes, at Easton Memorial 327 minutes, and at Prince George's 550 minutes.

¹⁰ Centers for Disease Control and Prevention (2014). Emergency Department Visits: Data for U.S. May 14, 2014.

¹¹ U.S. Government Accountability Office Report, *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use*, April 11, 2011.

¹² The Henry J. Kaiser Family Foundation (2014). Hospital Emergency Room Visits per 1,000 Population by Ownership Type. <http://kff.org/other/state-indicator/emergency-room-visits-by-ownership/>

¹³ American College of Emergency Physicians (2014). America's Emergency Care Environment, A State-by-State Report Card-2014. <http://www.emreportcard.org/uploadedFiles/EMReportCard2014.pdf>

¹⁴ Available at <https://www.marylandqmdc.org/Article/View/7834a19c-25bd-4334-a5d5-71901b54aac6>

Strategies to Reduce Emergency Department Use

The Centers for Medicare and Medicaid Services (CMS) identified several strategies to reduce emergency department utilization, especially in terms of non-emergent use.¹⁵ These strategies were based on the findings from a CMS-supported Emergency Room Diversion grant program that operated in 20 states between 2008 and 2011. Key strategies included focusing on providing for the needs of individuals who are frequent users of emergency departments, defined as individuals with four or more visits per year, as well as broadening access to primary care services and urgent care centers.

Urgent Care Centers: Overview and Trends

The American Academy of Urgent Care Medicine defines urgent care as “the provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness and injury.”¹⁶ There are approximately 10,000 urgent care clinics (or centers) in the U.S today, and according to the Urgent Care Association of America, it is one of the fastest growing fields in health care today.¹⁷ The 2014 Urgent Care Survey provides several explanations for the rapid growth in the industry including convenience and cost:

- Most urgent care centers offer extended hours (usually 8 am to 8 pm seven days a week) to accommodate a variety of patient schedules.
- Many clinics are conveniently located near shops, schools, and places of work.
- Patients are often seen within 30 minutes at an urgent care center
- The average charge at an urgent care center is less than \$150, compared to the \$1,354 cost for the average emergency department visit.¹⁸

Urgent care centers are often distinguished from hospital emergency departments by the scope of care and services that they provide. Unlike hospital emergency departments, urgent care centers are not equipped to handle major trauma injuries or severe medical issues such as heart attacks or uncontrollable bleeding. While they do provide walk-in care and extended hours, urgent care centers are not open 24 hours a day seven days a week. Urgent care centers, unless they are affiliated with a hospital, do not have Emergency Medical Treatment and Labor Act (EMTALA) obligations. Thus, they may not accept all types of insurance and may require full payment at the time of service, if the patient lacks insurance.

III. Freestanding Emergency Centers: Overview and Trends

Unlike urgent care centers, freestanding emergency centers are generally open 24 hours per day and seven days per week and accept patients via 911 ambulance services. Maryland’s FMFs are licensed as health care facilities and rate-regulated as components of their parent hospital or

¹⁵ Centers for Medicaid & Medicare Services (2014). Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. CMCS Informational Bulletin, January 16, 2014.

¹⁶ The American Academy of Urgent Care Medicine <http://aaucm.org/about/urgentcare/default.aspx>

¹⁷ Urgent Care Association of America (2014) <http://www.ucaoa.org/>

¹⁸ Medical Expenditure Survey Panel (2011) <http://meps.ahrq.gov/mepsweb/>

hospital system. However, in other states, freestanding emergency centers can be affiliated with a hospital or independently owned and operated. According to a May 18, 2011 report by *The Journal of the American Medical Association*, an estimated 284 freestanding emergency centers exist in at least 45 states in the United States.¹⁹ This is an increase of 62 such facilities since 2009. For context, the American Hospital Association reports that there were 5,723 acute care hospitals in the United States in 2012.

Research conducted by the California Health Care Foundation found that the objectives for constructing freestanding emergency centers most commonly cited by hospitals include the following:

- Provide enhanced access to care and meet an increasing demand for emergency services;
- Develop sites and services that differentiate the organization from its competitors;
- Gain increased market share;
- Provide a referral source for affiliated physicians;
- Increase the potential for referring patients for hospital-based services; and,
- Increase the potential for mitigating competitive threats.

Virginia is among the states where this business model for emergency medical service delivery has rapidly proliferated. In northern Virginia, Inova Health System operates five freestanding emergency centers in conjunction with five general acute care hospitals and six urgent care centers. The latter operate for 11 to 12 hours per day on weekdays, eight hours on weekends and holidays, on every day or almost every day of the year.²⁰

Maryland first officially recognized freestanding emergency centers through creation of the licensure category of freestanding medical facility in 2005 and has limited use of this license, initially, to two pilot facilities. The third licensed freestanding medical facility in Maryland, the Bowie Health Center, has functioned as a freestanding medical facility since its inception in 1980 without a distinct licensure designation, but was licensed as an FMF after this licensure category was established.²¹ The two freestanding emergency centers established as pilot projects

¹⁹ Hsia, R.Y., Kellerman, A.L., & Shen, Y. (2011). Factors Associated With Closures of Emergency Departments in the United States," *JAMA*. 2011;305(19):1978-1985.

²⁰ Virginia has not regulated freestanding emergency centers as distinct facilities. The Inova centers operate within the scope of their parent hospital license. Virginia does not regulate charges at hospitals or other health care facilities.

²¹ The HSCRC has set rates, and continues to set rates for the Bowie Health Center, which is part of Dimensions Health System and operates under the auspices of Prince George's Hospital Center. In 1980, the law was clear that the HSCRC had rate setting jurisdiction over hospitals; however, it did not delineate HSCRC jurisdiction over outpatient hospital services. The term "at the hospital" was not defined either by administrative structure or by physical location. Thus, while Bowie was not licensed as a hospital, the HSCRC asserted rate jurisdiction over Bowie because it considered the facility to be administratively part of the umbrella hospital, Prince George's Hospital Center, under whose license it operated. The HSCRC was willing to accommodate Bowie and assume rate jurisdiction because Bowie had been approved in 1977 for a Certification of Conformance from Maryland's State Health Planning and Development Agency (predecessor to the Maryland Health Care Commission) to build a new hospital and primary care center in the location. Rather than have a new hospital built, which in the HSCRC's view would have exacerbated the State's excess hospital capacity problem, the HSCRC was willing to set rates for the scaled-back ambulatory/emergency care facility, known as the Bowie Health Center. Thus, the HSCRC's decision to

are the Germantown Emergency Center in Montgomery County, which opened in August 2006, and the Queen Anne's Emergency Center in Queen Anne's County, opened in October 2010.

IV. Description of Maryland Freestanding Medical Facilities

Germantown Emergency Center

The first pilot FMF project, Adventist HealthCare Germantown Emergency Center (Germantown Emergency Center), was established under the auspices of Adventist HealthCare Shady Grove Medical Center (SGMC), known until recently as Shady Grove Adventist Hospital. SGMC is a member of Adventist HealthCare, Inc., a merged asset system that includes Washington Adventist Hospital as well as facilities providing specialty hospital and home health agency services. The Germantown Emergency Center, which opened on August 7, 2006, is located in Montgomery County at 19731 Germantown Road in Germantown. It is housed in a 17,000 square foot building adjacent to a physician office building.

Montgomery County, which has six acute care hospitals, is the State's largest jurisdiction. The most recent population estimates from the U.S. Census Bureau (2013) show that Montgomery County's total resident population has increased by nearly 150,000 since 2000, from 873,341 to 1,016, 677 in 2013. Projections prepared by the Maryland Department of Planning suggest that Montgomery County's population is expected to increase to 1,081,436 by 2023.

Germantown Emergency Center maintains a total of 21 treatment spaces, as described in Table 2 below. The Center is described, on its website, as providing the same emergency medical care that patients can receive at a hospital emergency department. In the fiscal year that ended December 31, 2013, Germantown Emergency Center reported 56.1 full-time equivalent staff.²²

Table 2
Number of Emergency Treatment Spaces by Category:
Germantown Emergency Center (as of June 1, 2013)

Emergency Treatment Category	Treatment Spaces
All Purpose, Monitored	9
All Purpose, Non-Monitored	12
Total Treatment Spaces	21
Triage	2
Total Non- Treatment Spaces	2

Source: MHCC Supplemental Survey: Emergency Department
Treatment Capacity as of June 1, 2013, Annual Report on Selected Maryland Acute Care
and Special Hospital Services, FY 2014.

exercise its discretion and rate regulate Bowie was part of an agreement among the parties and consistent with Maryland law at the time.

²² HSCRC Cost Report.

Table 3 shows the driving distances from the Germantown Emergency Center to other acute care hospitals. Maryland's newest general hospital, Holy Cross Germantown Hospital, which opened in October 2014, is within two miles of Germantown Emergency Center. The facility is located nine miles from Shady Grove Medical Center and 17.5 miles from Montgomery General Hospital in Olney. Frederick Memorial Hospital is approximately 23 miles from the Germantown facility.

Table 3
Estimated Driving Distance from
Selected Acute Care Hospitals to the to the Germantown Emergency Center

Hospital	Driving Distance (in miles)
Holy Cross Germantown Hospital	1.7
Shady Grove Medical Center	9.0
Montgomery General Hospital	17.5
Suburban Hospital	18.1
Holy Cross Hospital of Silver Spring	22.0

Source: Spatial Insights, Inc.

Within the five-mile radius surrounding the Germantown Emergency Center, there are about 216,282 Montgomery County residents. The population increases to about 411,439 within a 10-mile radius of the facility. Map 2 shows patterns of population growth between 2000 and 2014 in the areas surrounding the Germantown Emergency Center.

Queen Anne's Emergency Center

In 2007, the General Assembly modified the freestanding medical facilities law to add a second pilot project site located in Queen Anne's County. The Queen Anne's Emergency Center opened in October of 2010, and was established under the auspices of the University of Maryland Medical System ("UMMS"). UMMS is a merged asset system with eleven general acute care hospitals, including the three-hospital Shore Health System, as well as specialty hospital facilities. The acute care hospitals that are part of the Shore Health System are UM Shore Medical Center at Easton (Talbot County), UM Shore Medical Center at Dorchester (Dorchester County), and UM Shore Medical Center at Chestertown (Kent County). The Queen Anne's Emergency Center is affiliated with UM Shore Medical Center at Easton.

Queen Anne's County is one of two Maryland counties without a general hospital operating within its borders. Its residents seek hospital emergency department and acute care hospital services in neighboring jurisdictions on the Eastern Shore (there are UM Shore hospitals in the bordering counties of Kent and Talbot) and in Anne Arundel County on the western shore. The most recent population estimates from the U.S. Census Bureau show that Queen Anne's total resident population increased from 40,560 in 2000 to 47,798 in 2014, an increase of 7,238. Among all Maryland jurisdictions, Queen Anne's County ranked 5th in terms of population growth between 2010 and 2014, with a growth rate of 17.8 percent. Projections prepared by the Maryland Department of Planning show that the population of Queen Anne's County is expected to increase to 55,650 by 2020.

Queen Anne’s Emergency Center has a total of 14 treatment spaces, as described in Table 4 below. According to the University of Maryland School of Medicine, the site has full on-site diagnostic imaging and laboratory services as well as multiple specialty rooms. In addition to the freestanding medical facility, the campus houses an additional medical office building. In the fiscal year ending June 30, 2014, Queen Anne’s Emergency Center reported 38.7 full-time equivalent²³.

Table 4
Number of Emergency Treatment Spaces
by Category: Queen Anne’s Emergency Center, (as of June 1, 2013)

Emergency Treatment Category	Treatment Spaces
All Purpose, Monitored	14
All Purpose, Non-Monitored	0
Total Treatment Spaces	14
Triage	1
Non-Treatment Spaces	1

Source: Maryland Health Care Commission, Supplemental Survey: Emergency Department Treatment Capacity as of June 1, 2013, Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2014.

The Queen Anne’s Emergency Center is approximately 21 miles from the UM Shore Medical Center at Easton in Talbot County and 24 miles from Anne Arundel Medical Center in Anne Arundel County, the two closest general hospitals to the FMF, in terms of distance. Table 5 shows the estimated driving distance between Queen Anne’s Emergency Center and the five nearest hospitals.

Table 5
Estimated Driving Distance from
Five Nearest Hospitals to the Queen Anne's Emergency Center

Hospital /Jurisdiction	Driving Distance (in miles)
UM Shore Medical Center at Easton/ Talbot County	21.3
Anne Arundel Medical Center/ Anne Arundel County	23.9
UM Shore Medical Center at Chestertown/ Kent County	29.3
Baltimore Washington Medical Center/ Ann Arundel County	33.5
UM Shore Medical Center at Dorchester / Dorchester County	36.0

Source: Spatial Insights, Inc.

²³ HSCRC Cost Report.

Bowie Health Center

The Bowie Health Center, which is a part of Dimensions Health System, operates under the auspices of the Prince George's Hospital Center (PGHC). The Bowie Health Center opened in 1979 and was licensed by the Office of Health Care Quality as a freestanding medical facility, as of June 13, 2007. Between 1979 and 2007, it operated within the authority of PGHC's general hospital license. The Center is located on a 50-acre property at 15001 Health Center Drive in Bowie, Maryland. The site also includes a freestanding ambulatory surgical facility, Dimensions Surgery Center, a comprehensive care facility (nursing home), Larkin Chase Care and Rehabilitation Center, and a medical office building.

The most recent population estimates from the U.S. Census Bureau show that Prince George's County's total resident population increased from 863,420 in 2010 to 890,081 in 2013. It is the second most populous county in Maryland. Bowie Health Center maintains a total of 21 treatment spaces, as shown in Table 6. On its website, Bowie Health Center is described as a provider of Level 2 emergency services, laboratory services, and radiology services (diagnostic X-ray). In the fiscal year ending June 30, 2014, Bowie Health Center reported 70.0 full-time equivalent staff²⁴.

Table 6
Number of Emergency Treatment Spaces
by Category: The Bowie Health Center, (as of June 1, 2013)

Emergency Treatment Category	Treatment Spaces
All Purpose, Monitored	21
All Purpose, Non-Monitored	0
Total Treatment Spaces	21
Triage	2
Total Non- Treatment Spaces	2

Source: MHCC, Supplemental Survey: Emergency Department Treatment Capacity as of June 1, 2013, Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2014.

There are seven hospitals, located in three jurisdictions, within 20 miles driving distance and 11 additional Maryland hospitals are within 30 miles. Table 5 shows the driving distances from the Bowie Health Center to general hospitals. Bowie Health Center is located closest to Doctor's Community Hospital (9.2 miles). The second closest general hospital is the FMF's parent hospital, Prince George's Hospital Center (10.6 miles). Anne Arundel Medical Center is approximately 12.8 miles from Bowie Health Center.

²⁴ HSCRC Cost Report.

Table 7
Estimated Driving Distance from
Five Nearest Hospitals to the Bowie Health Center

Hospital	Driving Distance (in miles)
Doctor's Community Hospital	9.2
Prince George's Hospital Center	10.6
Anne Arundel Medical Center	12.8
Laurel Regional Hospital	15.4

Source: Spatial Insights, Inc.

Within the five-mile radius surrounding the Bowie Health Center, there are about 113,758 residents. The estimated population increases to about 482,842 within a 10-mile radius of the facility.

V. Financial Performance and Impact of Rate Regulation

The Germantown Emergency Center is the only freestanding medical facility that has operated both before and after HSCRC began regulating rates for freestanding medical facilities on July 1, 2011. The Queen Anne's Emergency Medical Center has only operated as a rate-regulated FMF, and Bowie Health Center also has only operated as a rate regulated facility, although the manner in which it has been rate regulated has changed. As described in further detail below, the financial performance of Germantown Emergency Center suggests that rate setting by HSCRC was not clearly advantageous or disadvantageous.

As shown in Table 8, the net income for Germantown Emergency Center has been negative since opening. Each year expenses exceeded net revenue, including the period after HSCRC began regulating its charges. Germantown Emergency Center achieved its best financial performance during the fiscal years 2010 through 2012, a period that encompasses the fiscal year before rate regulation. HSCRC's rate regulation went into effect for Germantown Emergency Center six months after GEC's FY 2011 began. In FY 2010, GEC had a net loss of less than \$200,000, far better than the loss of approximately \$1.5 million reported for FY 2009. In FY 2011, GEC had its second best financial performance, with a loss of approximately \$340,000, and its net loss remained below \$400,000 in FY 2012. However, in FY 2013, GEC reported a net loss of almost \$1.9 million. Both the amount of bad debt and charity care were much higher in FY 2013 as compared to FY 2011 and FY 2012. As a result, the net revenue for GEC was almost \$1 million lower in FY 2013 (\$9.4 million) as compared to FY 2012 (\$10.4 million). A representative from SGMC with knowledge of the financial performance of GEC explained to MHCC staff that a new information management system was put in place in December 2011, and this resulted in a lag in writing off bad debt. It was also noted that SGMC agreed to a global budget effective July 1, 2013, which effectively reduced the reimbursement for services at GEC.

Table 14 shows how revenue, charity care, bad debt, operating expenses, and net revenue have changed over time on a per-case basis. For FY 2013, the year that GEC reported its worst

financial performance to date, the amount of charity care, bad debt, and expenses reported are not inconsistent with other years for the period FY 2007 to FY 2013. However, the gross revenue per case has been declining since 2010, when it reached a peak of \$507 per visit. Gross revenue per case was only \$407 in FY 2013, almost 20 percent lower.

Under SGMC's global budget agreement with HSCRC, the allowable revenue for GEC for FY 2014, which ended on December 31, 2014, is approximately \$13.9 million, which is slightly less than the gross revenue for FY 2013. For FY 2015, the allowable revenue is approximately \$14.2 million. Although GEC was able to obtain a facility fee from Medicare after becoming rate regulated, which may have been expected to increase revenue, GEC had lower gross revenue in each of the three years following rate regulation (FY 2011 to FY 2013), as compared to the three years prior to rate regulation (FY 2008 to FY 2010). Based on the varied financial performance for GEC both before and after rate regulation, it does not appear that GEC was clearly advantaged or disadvantaged by becoming rate regulated.

Despite the appearance that GEC has not achieved a profit since it began operating, representatives for SGMC noted that due to regulatory requirements requiring ED visits to be bundled with the inpatient admission, charges accumulated at Germantown Emergency Center for patients who are ultimately admitted at Shady Grove Medical Center are moved from the Germantown Emergency Center to Shady Grove Medical Center and billed as part of the inpatient admission. However, the expenses for emergency services provided at GEC remain attributed to Germantown Emergency Center. This causes the profit at Germantown Emergency Center to appear artificially low, as it does not account for the revenue generated by patients who are admitted. Based on information provided by SGMC regarding the estimated revenue that may be more appropriately attributed to GEC, approximately a half million dollars, GEC may have achieved a small profit in some of the years that it has operated.

Table 8
Financial Performance and
Number of Visits: Germantown Emergency Center, Fiscal Years 2007- 2013.

	2007	2008	2009	2010	2011	2012	2013
Gross Revenue	\$ 11,667,400	\$ 14,912,500	\$ 17,005,100	\$ 16,364,600	\$ 14,190,645	\$ 14,173,644	\$ 14,047,709
Charity	\$ 333,600	\$ 1,014,000	\$ 885,300	\$ 1,016,200	\$ 585,752	\$ 581,478	\$ 1,076,975
Bad debt	\$ 1,295,600	\$ 2,105,400	\$ 2,525,000	\$ 1,321,700	\$ 970,899	\$ 2,177,255	\$ 2,349,356
Contractual Adjustments	\$ 2,223,200	\$ 2,738,000	\$ 4,278,400	\$ 3,476,300	\$ 2,307,144	\$ 1,064,746	\$ 1,232,257
Net Revenue	\$ 7,815,000	\$ 9,055,100	\$ 9,316,400	\$ 10,550,400	\$ 10,326,850	\$ 10,350,165	\$ 9,389,121
Other Operating Revenue	\$ 427,300	\$ 425,000	\$ 535,100	\$ 551,800	\$ 538,967	\$ 563,563	\$ 586,517
Total Net Revenue	\$ 8,242,300	\$ 9,480,100	\$ 9,851,500	\$ 11,102,200	\$ 10,865,817	\$ 10,913,728	\$ 9,975,638
Expenses	\$ 9,236,900	\$ 10,327,400	\$ 11,363,000	\$ 11,273,100	\$ 11,209,022	\$ 11,301,937	\$ 11,874,767
Income	\$ (994,600)	\$ (847,300)	\$ (1,511,500)	\$ (170,900)	\$ (343,205)	\$ (388,209)	\$ (1,899,129)
Visits	26,113	30,302	33,737	32,258	33,805	34,352	34,477

Source: The data for 2007-2010 is from HSCRC cost reports schedule RE-R; the data for 2011-2013 is from Adventist Healthcare audited financial statements.

Notes: The total number of visits does not include patients transferred and admitted to SGMC. The fiscal year for GEC is January- December.

Table 9
Per Visit Costs and Revenue:
Germantown Emergency Center, Fiscal Years 2007-2013

	2007	2008	2009	2010	2011	2012	2013
Gross revenue	\$447	\$492	\$504	\$507	\$420	\$413	\$407
Charity	\$13	\$33	\$26	\$32	\$17	\$17	\$31
Bad debt	\$50	\$69	\$75	\$41	\$29	\$63	\$68
Net revenue	\$299	\$299	\$276	\$327	\$305	\$301	\$272
Expenses	\$354	\$341	\$337	\$349	\$332	\$329	\$344
Income	(\$38)	(\$28)	(\$45)	(\$5)	(\$10)	(\$11)	(\$55)

Sources: Financial information is from copies of financial statements obtained from HSCRC for FY 2011-13. The total number of visits is based on MHCC analysis of the freestanding medical facilities data.

Note: The fiscal year for GEC is January – December.

VI. Comparison of Freestanding Medical Facilities

This section of the report presents comparative information for Maryland's three FMFs. A detailed profile for each freestanding medical facility is included in Appendix 4. The major data sets used by the Maryland Health Care Commission to develop this section of the report and Appendix 4 include the following sources:

- Freestanding Medical Facilities Data Base (MHCC and HSCRC);
- Financial Data Base (HSCRC);
- Maryland Hospital Outpatient Data Base (HSCRC); and,
- Maryland Inpatient Discharge Data Base (HSCRC).

A description of the Freestanding Medical Facility data bases, as well as the data collection and reporting procedures, can be found in Appendix 5.

Service Area and Population Served

The Germantown Emergency Center and the Bowie Health Center are located in the two largest jurisdictions of the State, Montgomery County and Prince George's County respectively. Each county is characterized by dense urban and suburban development. As shown in Table 41, an estimated half a million individuals reside within a ten-mile radius of the Bowie Health Center and 400,000 people reside within a ten-mile radius of the Germantown Emergency Center. Both of these freestanding medical facilities have at least one hospital within a ten-mile radius, and multiple hospitals are located within a 40-mile radius. In contrast, the Queen Anne's Emergency Center is located in a county with a population of less than 50,000 people. There are no hospitals located in Queen Anne's County or within a ten-mile radius of QAEC, as shown in Table 11. In contrast, both Germantown Emergency Center and Bowie Health Center are located in counties with multiple hospitals, and there is at least one hospital within a ten-mile radius of each.

Table 10
Population Within Five and Ten Miles of
Maryland Freestanding Medical Facilities, 2014

Facility	Population Within Five Miles	Population Within Ten Miles
Germantown Emergency Center	216,285	411,439
Queen Anne's Emergency Center	9,057	32,933
Bowie Health Center	113,758	482,842

Source: Spatial Insights' analysis of U.S. Census 2014 population estimates.

Table 11
Distance to General Hospitals from
Maryland Freestanding Medical Facilities

Facility	Distance to Nearest Hospital	Distance to Affiliated Hospital	Number of Hospitals Within Ten Miles	Number of Hospitals Within 40 Miles
Germantown Emergency Center	1.7	9.0	2	12
Queen Anne's Emergency Center	21.3	21.3	0	5
Bowie Health Center	9.2	10.6	1	31

Source: Spatial Insights, Inc.

Notes: The number of hospitals identified with ten miles and forty miles of each FMF is based on driving distance. The hospitals affiliated with GEC, QAEC, and Bowie, are SGMHC, UM Shore Medical Center at Easton, and PGHC, respectively.

Utilization and Treatment Capacity

Table 12 shows the volume of visits for each of the three Maryland freestanding facilities and their affiliated hospitals for the period FY 2012 to FY 2014. There was an increase in the utilization of emergency services at two of the three freestanding emergency centers in Maryland between 2012 and 2014. The total visits increased by about 5% at Germantown Emergency Center and by 6% at Queen Anne's Emergency Center. The total visits at Bowie Health Center decreased by about 2% during the same period. All three of the hospitals affiliated with these freestanding medical facilities had a lower volume of visits in FY 2014 as compared to FY 2012, ranging from approximately -2.7% at Shady Grove Medical Center to -5.7% at UM Shore at Easton.

Table 12
Total Visits: Maryland Freestanding Medical Facilities
and Nearest Affiliated Hospital ED, Fiscal Years 2012-2014

Facility	2012	2013	2014
Germantown Emergency Center	35,530	38,018	37,247
Queen Anne's Emergency Center	13,589	14,059	14,435
Bowie Health Center	36,164	36,811	35,344
Shady Grove Medical Center	73,492	75,693	71,531
UM Shore at Easton	38,003	38,147	35,839
Prince George's Hospital Center	52,616	52,373	50,284

Sources: MHCC staff analysis of freestanding medical facilities data, outpatient data, and inpatient data; SGMCC staff provided the total number of visits for July 1, 2012 to December 31, 2012 and FY 2013-2014.

Notes: The 2012 total number of visits for GEC is an estimate based on six months of reported visits; for all locations, the fiscal year refers to the State fiscal year, which begins July 1 and ends June 30.

The Germantown Emergency Center, with 21 treatment spaces, served an average of 1,810 patients per treatment space in FY 2013, a higher rate of capacity use, as compared to Shady Grove Medical Center's ED (1,183), other Montgomery County hospital EDs (1,320), and the statewide rate for hospital EDs collectively (1,275). The Bowie Health Center, also with 21 treatment spaces, had a relatively high level of capacity use with 1,753 visits per treatment space. Prince George's Hospital Center ED had only 1,114 visits per treatment space in 2013. In contrast, the Queen Anne's Emergency Center, with 14 treatment spaces, served an average of 1,003 patients per treatment space. This was a lower level of capacity use as compared to the UM Shore Medical Center at Easton (1,122 visits per treatment space). The service capacity and visits per treatment space are shown in Table 13 and Table 14 respectively.

Table 13
Service Capacity for Maryland Freestanding Medical Facilities

Facility	Treatment Spaces	Other Spaces (Triage)	Total Patient Spaces
Germantown Emergency Center	21	2	23
Queen Anne's Emergency Center	14	1	15
Bowie Health Center	21	2	23

Source: MHCC Supplemental Survey: Emergency Department Treatment Capacity as of June 1, 2013. *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2014.*

Table 14
Number of Visits Per Treatment Space for Maryland Freestanding Medical Facilities, FMF Affiliated Hospitals, and Hospital EDs, Fiscal Year 2014

Facility	Visits per Treatment Space
Germantown Emergency Center	1,810
Queen Anne's Emergency Center	1,031
Bowie Health Center	1,753
Shady Grove Medical Center	1,183
UM Shore at Easton	1,054
Prince George's Hospital Center	1,114
All Maryland Hospital EDs	1,275

Sources: MHCC staff analysis of freestanding medical facilities data; SGMC staff; *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2014.*

The number of treatment spaces at all three freestanding emergency facilities in Maryland has remained the same since each facility's opening or licensing as an FMF. Statewide, however, there has been an increase over the last decade in the total number of treatment spaces in hospital emergency departments every year. In 2009, Maryland hospitals served 1,355 emergency department visits per treatment space. By 2013, this ratio had declined to 1,275 visits per treatment space for all Maryland hospital EDs.

Patient Characteristics

Among patients discharged following treatment, both the Germantown Emergency Center and the Shady Grove Medical Center ED serve a population that is younger than the statewide average for Maryland hospital EDs, as shown in Table 15. During FY 2014, 11.0% of patients served at GEC were five years of age or younger, as compared to 10.8% of ED visits at SGMC, and 5.3% for all Maryland hospital EDs. Patients aged six to 15 accounted for about 13.5% of the total number of visits at GEC that did not result in admission to an acute care hospital, as compared to 7.6% patients for SGMC ED visits and 5.5% statewide at Maryland hospital EDs. Patients over age 65 accounted for 5.0% of visits at GEC, as compared to 15.9% of ED visits at SGMC, and 22.3% for all Maryland hospital EDs.

As compared to the Shore Medical Center at Easton and the statewide average for all hospital EDs, the population served at Queen Anne's Emergency Center is younger. During FY 2014, 8.4% of visits at QAEC were for patients age five or younger, as compared to 4.6% for UM Shore Medical Center at the Easton ED and 5.3% statewide for all Maryland hospital EDs. There were also almost three times as many visits for patients between the ages of six and 15 at QAEC (12.3%), as compared to UM Shore Medical center (4.4%). Patients age 65 and older comprised only 13.6% of visits at Queen Anne's Emergency Center, as compared to 28.5% of visits at Shore Medical Center at Easton and 22.3% of ED visits for all Maryland hospitals.

As shown in Table 15, similar to the other freestanding medical facilities, the population served at Bowie Health Center was younger as compared to its affiliated hospital and the statewide average for all Maryland hospital EDs. In FY 2014, 8.5% of visits at Bowie Health Center were for patients age five and younger, as compared to 4.1% for Prince George's Hospital Center's ED and 5.3% statewide for all Maryland hospital EDs. Patients between the ages of six and 15 also comprised a much higher proportions of visits at Bowie Health Center (10.6%), as compared to ED visits at Prince George's Hospital Center (4.0%) and statewide for all Maryland hospital EDs (5.5%). Compared to the other Maryland freestanding medical facilities, there is much less of a difference between Bowie Health Center and its affiliated hospital, with respect to the proportion of patients who are age 41-65 or age 65 and older. Patients age 65 and older comprised 9.3% of visits at Bowie Health Center, as compared to 7.2% for Prince George's Hospital Center. Nearly the same proportion of visits at both locations were for patients age 41-65, approximately 32%. Statewide, for all Maryland hospital EDs 22.3 percent of ED patients were 65 or older, which is a much higher proportion of visits, as compared to both Bowie Health Center and Prince George's Hospital Center.

Table 15
Age Distribution of Patients
Maryland Freestanding Medical Facilities and Nearest Affiliated Hospital ED, 2014

Age Group	Germantown FMF	Shady Grove ED	Queen Anne's FMF	Shore at Easton ED	Bowie FMF	Prince George's ED	All Maryland Hospital EDs
0-5	11.4	10.8	8.4	4.6	7.5	5.0	5.3
6-15	13.5	7.6	12.3	4.4	10.6	4.0	5.5
16-25	18.1	11.1	16.1	10.5	17.1	22.1	10.4
26-40	25.1	20.6	20.3	16.2	23.8	30.2	18.3
41-65	27.3	34.1	29.4	38.4	31.7	31.5	38.2
65+	5.0	15.9	13.6	28.5	9.3	7.2	22.3

Source: HSCRC outpatient data and freestanding medical facilities data set.

Notes: Percentages are rounded to the nearest one-tenth percent; the data for Germantown FMF reflect only patients discharged following treatment; the data for Queen Anne's FMF and Bowie FMF reflect all visits.

The younger population served by freestanding medical facilities likely reflects both the age demographic of the population in their service areas and the acuity of patients. Shorter wait

times, or the perception that wait times will be shorter at a freestanding medical facility, may be a factor for parents of children or those with lower acuity problems who do not anticipate admission to a hospital is needed. Representatives from SGMCM specifically noted that they believe the shorter waiting time at GEC appeals to some patients. For patients age 65 years and older, who tend to be admitted at a much higher rate than younger patients, self-selection and the transport protocols for EMS may be factors contributing to the higher proportion of these patients at hospitals compared to freestanding medical facilities, even though patients admitted to a hospital following an ED visit have been excluded from the age distribution calculations for all hospitals.

Although the age distribution of the population residing within a five-mile radius of a Maryland freestanding medical facility may not consistently correspond with the relative proportion of visits among these facilities, it appears to be a key factor affecting the age distribution of visits at Maryland's freestanding medical facilities. Compared to the population residing within a five-mile radius of Queen Anne's Emergency Center, the population residing within a five-mile radius of either Germantown Emergency Center or Bowie Health Center is much younger. Approximately 20.3% of the population within a five-mile radius of Queen Anne's Emergency Center is 65 years of age or older, as compared to 9.0% for Germantown Emergency Center and 13.2% for Bowie Health Center.²⁵ Consistent with these differences, the percentage of visits at QAEC for those age 65 years and older (13.6%) is more than twice the percentage of visits at Germantown Emergency Center (5.0%) and a much greater percentage of visits than for Bowie Health Center (9.3%). There is less difference among the freestanding facilities with regard to the percentage of the population within a five-mile radius that is under age 15, ranging from 16.8% for Queen Anne's Emergency Center to 21.5% for Germantown Emergency Center. Consistent with this information, the proportion of visits at GEC for patients age 15 and younger (24.9%) is much higher than for QAEC (20.7%) and Bowie Health Center (18.1%). However, QAEC did not have the lowest proportion of visits for this age cohort, even though it has the lowest percentage of its population under age 15, among the three freestanding medical facilities.

As compared to their affiliated hospitals and the statewide average for all hospital EDs, Maryland freestanding medical facilities serve a lower acuity population, as evidenced by both coding of patient visits and the lower hospital admission rates. The acuity level for visits at Maryland freestanding medical facilities in FY 2014 is shown in Table 17. The methodology for classifying the acuity level of patient visits is described in Appendix 6. In FY 2014, less than 1% of the patients seen at the Germantown Emergency Center were classified as very high acuity patients (Level V), as compared to 8.1% for ED visits at SGMCM and 12.9% statewide in hospital EDs. For Queen Anne's Emergency Center, the level of patient acuity is more comparable to the level for its affiliated hospital, UM Shore Medical Center at Easton, as seen with Germantown Emergency Center. In FY 2014, 3.4% of visits at Queen Anne's Emergency Center were classified as very high acuity, as compared to 5.2% at UM Shore Medical Center at Easton. With fewer alternative locations for emergency care in or near Queen Anne's Emergency Center, it may need to function as a resource for emergency medical services that is very similar to the way the emergency department at its affiliated hospital functions. For Bowie

²⁵ Spatial Insights

Health Center, the level of patient acuity is much lower than the level for its affiliated hospital, Prince George's Hospital Center, as was the case for Germantown Emergency Center. In FY 2014, 9.1% of visits were classified as very high acuity at Bowie Health Center, as compared to 35.8% at Prince George's Hospital Center.

There were slightly more very high acuity patients (Level V) seen at Germantown Emergency Center in FY 2014 (0.9%), as compared to FY 2008 (< 0.1%). An increase in the percentage of very high acuity patients (Level V) was also reported by Bowie Health Center over this time period; the percentage of visits classified as very high acuity increased from 2.0% in FY 2008 to 9.1% in FY 2014. In contrast, the percentage of very high acuity visits decreased at Queen Anne's Emergency Center between its first year of operation and FY 2014; in FY 2011, 4.7% of visits were classified as high acuity, compared to 3.4% in FY 2014.

In FY 2014, Queen Anne's Emergency Center reported the highest proportion of very low acuity patients (Level I), 4.7%, as compared to Germantown Emergency Center (0.8%) and Bowie Health Center, which reported no visits for this category. At both Germantown Emergency Center and Bowie Health Center, the percentage of low acuity visits has declined, replaced by a greater proportion of visits classified as moderate acuity.

In FY 2014, the majority of patients seen at Maryland freestanding emergency facilities were classified as moderate acuity (Level III). At Germantown Emergency Center, the proportion of visits classified as moderate acuity increased substantially from FY 2008 (31%) to FY 2014 (51%), with the largest increase occurring between FY 2011 and FY 2012. At Queen Anne's Emergency Center, the proportion of moderate acuity visits has increased since it began operating in FY 2011, from 53.1% to 69.5% in FY 2014, with the largest increase between FY 2011 and FY 2012. At Bowie Health Center, the proportion of moderate acuity visits has also increased substantially from FY 2008 to FY 2014, from 10.2% to 53.0%, with the largest increase between FY 2013 and FY 2014. Both HSCRC staff and representatives for Dimensions HealthCare have explained that Bowie Health Center was incorrectly classifying its visits between 2010 and 2013 and that a higher proportion of its visits should have been classified as moderately acute or high acuity.

Table 17
Percentage of Visits by Acuity Level for
Freestanding Medical Facilities and Nearest Hospital Affiliated ED, FY 2014

Acuity Level	GEC	SGMC	QAEC	Shore at Easton	BHC	PGHC	All MD EDs
Level I	0.8	1.2	4.7	4.1	0.0	0.5	4.5
Level II	21.0	10.0	1.6	2.9	15.3	13.0	12.9
Level III	57.7	41.0	69.5	56.8	53.0	32.4	36.6
Level IV	19.6	35.0	20.8	30.9	22.5	17.0	31.6
Level V	0.9	8.1	3.4	5.2	9.1	35.8	12.9
Unknown	0.1	4.7	0.0	0.2	0.0	1.2	1.3

Source: MHCC staff analysis of freestanding medical facilities and outpatient data sets.

Notes: Visits resulting in admission to the hospital are not included. For this analysis, the fiscal year is defined as the twelve month period ending on June 30th.

The vast majority of patients evaluated at Maryland freestanding emergency centers are discharged to home following treatment. As shown in Table 18, only three to six percent of patient visits at Maryland freestanding emergency centers resulted in admission to the affiliated hospital or another general acute care hospital in FY 2012 to FY 2014, compared to 14.6% to 19.1% for ED visits at the hospitals affiliated with Maryland freestanding emergency centers.

Table 18
Number and Percentage of Patients Transferred
and Admitted to a Hospital by Location, Fiscal Years 2012-2014

Facility	Number Admitted			Percentage Admitted (%)		
	2012	2013	2014	2012	2013	2014
Germantown Emergency Center	1,886*	1,852	1,725	5.3	4.9	4.6
Queen Anne's Emergency Center	401	454	424	3.0	3.2	2.9
Bowie Health Center	1,548	1,787	2,087	4.8	5.3	5.9
Shady Grove Medical Center	13,403	13,194	10,460	18.2	17.4	14.6
UM Shore Medical Center at Easton	6,296	6,150	5,957	16.6	16.1	16.6
Prince George's Hospital Center	9,278	8,677	9,611	17.6	16.6	19.1

Sources: MHCC staff analysis of freestanding medical facilities data; Email correspondence from SGMC staff to MHCC staff, December 5, 2014.

Note: The freestanding medical facilities data set did not allow MHCC staff to identify which patients were admitted from GEC to SGMC; the number of patients admitted from GEC in 2012 and the percentage admitted is based on annualizing six months of data.

Given the overall lower acuity level of patients served in Maryland freestanding medical facilities, it is important to evaluate whether some of the population served in these freestanding

medical facilities could more appropriately be served in other settings, such as urgent care centers or primary care clinics. In addition, the development of urgent care centers in the vicinity of freestanding medical facilities could be expected to affect the volume of visits at freestanding medical facilities. However, representatives for SGMHC reported to MHCC staff that the nearby urgent care alternatives, which include a Righttime Medical Care and a walk-in clinic, have not had an observable impact on the volume of patient visits at Germantown Emergency Center. A representative for Dimensions Healthcare System commented that the primary concern with the urgent care centers is the potential negative impact on payer-mix for a freestanding medical facility through the loss of patients with commercial insurance.

Payment Source

The payer-mix for a freestanding medical facility has a major influence on the financial performance of the facility. Although HSCRC rates factor in bad debt and charity care in the previous fiscal year or multiple years, these adjustments may not always be fully recognized. In addition, reimbursement from commercial insurance is generally slightly better, as compared to reimbursement for patients with Medicaid or Medicare insurance.

In FY 2014, the most frequent payment source for care in Maryland hospital EDs was the Medicare program (26.9%), followed by the Medicaid program (23.8%). However, all three Maryland freestanding emergency centers had a much lower percentage of patients who were Medicare beneficiaries, ranging from 6.8% at Germantown Emergency Center to 15.4% at Queen Anne's Emergency Center. Overall, Medicare was the least frequent source of payment for patient visits at Germantown Emergency Center, which may be partly attributable to the younger population in its service area. It is likely that the higher proportion of patient visits at Queen Anne's Emergency Center for patients ages 65 and over accounts for its greater proportion of patients who are Medicare beneficiaries. The emergency departments for hospitals affiliated with the Maryland freestanding medical facilities also had a lower percentage of patients who were Medicare beneficiaries, ranging from 12.2% at Shady Grove Medical Center to 22.1% at UM Shore Medical Center at Easton.

Medicaid was the most frequent payment source at Germantown Emergency Center (33.1%) and at Queen Anne's Emergency Center (29.2%) in FY 2014. For Bowie Health Center, the most common source of payment was Blue Cross (26.3%). Although charity care was not reported by Bowie Health Center for visits in the data set analyzed by MHCC staff, representatives for Dimensions Healthcare explained that those patients were included in the category "self-pay." Similarly, Queen Anne's Emergency Center did not report charity care as a source of payment, but this likely reflects a reporting error.

Table 19
Percentage of Visits by Payment Source for Maryland
Freestanding Medical Facilities and Nearest Affiliated Hospital ED, Fiscal Year 2014

Payment Source	GEC	SGMC		QAEC	Shore at Easton		BHC	PGHC		All MD EDs
Blue Cross	12.3	13.6		16.1	10.0		26.3	9.5		15.7
Charity	0.0	0.1		0.0	0.2		-	-		1.0
Commercial	11.5	12.2		17.4	13.2		7.4	4.8		11.7
Medicaid	33.1	25.2		29.2	37.4		22.0	38.7		23.8
Medicare	6.8	12.2		15.4	22.1		10.2	8.8		26.9
Other	23.0	24.0		12.6	7.4		22.5	13.2		14.6
Self Pay	13.2	12.8		9.3	9.8		11.6	24.9		6.2
Unknown	-	-		-	-		-	-		0.0

Source: MHCC staff analysis of freestanding medical facilities and outpatient data sets.

Mode and Time of Arrival

For FY 2014, all three freestanding medical facilities reported that the majority of their visits occurred in the evening between 4 pm and midnight; the percentage ranged from 54.4% at Bowie Health Center to 59.8% at Queen Anne's Emergency Center. Approximately 80% to 90% of visits at these facilities in FY 2014 occurred between 8 am and midnight. Germantown Emergency Center had the highest proportion of visits between midnight and 8 am (20.8%), as compared to Bowie Health Center (11.8%) and Queen Anne's Emergency Center (9.3%). Table 16 shows the visits by registration time for all three facilities.

The majority of patients served by Maryland freestanding medical facilities are walk-in patients. In FY 2014, data reported on mode of arrival show that 95.2% of patients using the Germantown Emergency Center and 96.5% of patients using the Bowie Health Center walked in for service. The number of patients who arrived at these two locations by mode of arrival is shown in Table 16; data on mode of arrival for Queen Anne's Emergency Center was not reported in FY 2014. Freestanding medical facilities are not excluded from accepting patients using ambulance transportation, but the percentage of patients arriving by ambulance at freestanding medical facilities is very small.

Table 16
Distribution of Visits by Registration Time
and Arrival Mode: Maryland Freestanding Medical Facilities, FY 2014

Mode of Arrival and Fiscal Year	Number of Visits by Registration Time			Total	Percent Visits by Registration Time		
	Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight		Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight
GERMANTOWN							
Walk-in	6,679	7,292	18,659	32,630	19.5	21.3	54.4
Ambulance	400	325	849	1,574	1.2	1.0	2.5
Police	4	3	15	22	0.0	0.0	0.0
Unknown	34	8	23	65	0.0	0.0	0.1
Total	7,117	7,628	19,546	34,291	20.8	22.2	57.0
QUEEN ANNE'S	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total	1,306	4,317	8,375	13,998	9.3	30.8	59.8
BOWIE							
Walk-in	3,882	11,634	18,627	34,143	11.0	32.9	52.7
Ambulance	101	116	202	419	0.3	0.3	0.6
Police	7	1	6	14	0.0	0.0	0.0
Unknown	174	221	373	768	0.5	0.6	1.1
Total	4,164	11,972	19,208	35,344	11.8	33.9	54.4

Source: MHCC staff analysis of freestanding medical facilities data set.

Note: The data for Germantown Emergency Center includes only visits that did not result in transfer and admission to an acute care hospital. Visits by mode of arrival at registration time was not available for Queen Anne's Emergency Center.

Financial Performance

As shown in Table 20, the net income for each Maryland freestanding medical facility was negative for the three most recent fiscal years at each facility, with the exception of FY 2014 for Bowie Health Center. However, as previously noted, for Germantown Emergency Center, the financial statements do not capture revenue collected for visits that result in admission to Shady Grove Medical Center. SGMCC estimates that this revenue may be approximately \$500,000 and, if included for FY 2011 and FY 2012, Germantown Emergency Center would have had a small net profit of approximately \$100,000 to \$200,000 each year. In future years,

representatives for Dimensions Health System expect that Bowie Health Center may be profitable. However, HSCRC modified the division of revenue allocated to the components of the Dimensions Health System based on its assessment that the facility had been underpaid in previous years relative to the actual resources dedicated to patient care and that may fully account for Bowie Health Center's profit in FY 2014.

Each full fiscal year that Queen Anne's Emergency Center has operated, it had a net loss of income ranging from approximately \$1.9 million in FY 2012 to \$ 3.5 million in FY 2013, as shown in Table 20. These net income losses met or exceeded the worst year of financial performance for Germantown Emergency Center between FY 2007 and FY 2013. Germantown Emergency Center's worst financial performance occurred in FY 2013, when it reported a net loss of \$1.9 million.

The visit volume at Queen Anne's Emergency Center is much lower than the volume for Germantown Emergency Center, equivalent to approximately 36% of Germantown Emergency Center's volume over the most recent two-year period of FY 2012 to FY 2013. An unfavorable economy of scale could be a factor in the weaker financial performance of Queen Anne's Emergency Center. In FY 2014, there were only 14,059 visits at Queen Anne's Emergency Center, as compared to more than 37,000 for Germantown Emergency Center. As shown in Table 21, Queen Anne's Emergency Center had higher costs per visit compared to GEC and lower revenue per visit. The revenue per visit at Queen Anne's Emergency Center was approximately \$300 for FY 2011 to FY 2013, as compared to approximately \$400 for Germantown Emergency Center during this period. The cost per visit at Queen Anne's Emergency Center ranged from \$448 to \$539 during this period, compared to less than \$350 per visit at Germantown Emergency Center. The net results for Queen Anne Emergency Center were losses ranging from \$142 per visit to \$251 per visit for this period. In contrast, Germantown Emergency Center's net loss per visit ranged from \$10 to \$55.

The freestanding medical facility with the lowest expenses per visit is Bowie Health Center. Although its annual volume of visits in FY 2012 and FY 2013 was only about 5% to 7% higher compared to Germantown Emergency Center, the cost per visit was 20% and 15% lower in FY 2012 and FY 2013 respectively. Bowie Health Center's lower expenses per visit despite patients of similar or greater acuity, as compared to Germantown Emergency Center, should bode well for its future financial performance.

Table 20
Revenues, Expenses, and Income in Millions:
Maryland Freestanding Medical Facilities, FY 2011 to FY 2013 or FY 2012 to FY2014

	GERMANTOWN				QUEEN ANNE'S				BOWIE		
	2011	2012	2013		2011	2012	2013		2012	2013	2014
Gross Revenue	\$14.2	\$14.2	\$14.0		\$3.0	\$4.4	\$4.1		\$12.0	\$13.7	\$16.5
Charity	\$0.6	\$0.6	\$1.1		\$ 0	\$0	\$0.2		\$0.8	\$1.0	\$1.0
Bad debt	\$1.0	\$2.2	\$2.3		\$0.1	\$0.2	\$0.1		\$1.8	\$2.1	\$2.2
Contractual allowance	\$2.3	\$1.1	\$1.2		\$0	\$0	\$0		\$0.7	\$0.8	\$0.9
Net Revenue	\$10.3	\$10.4	\$9.4		\$2.9	\$4.1	\$4.0		\$8.7	\$9.8	\$12.4
Other Operating Revenue	\$0.5	\$0.6	\$0.6		\$0	\$0	\$0		\$0.0	\$0.0	\$0.0
Total Net Revenue	\$10.9	\$10.9	\$10.0		\$2.9	\$4.1	\$4.0		\$8.7	\$9.8	12.4
Expenses	\$11.2	\$11.3	\$11.9		\$5.1	\$6.1	\$7.6		\$9.3	\$10.8	\$10.5
Income	(\$0.3)	(\$0.4)	(\$1.9)		(\$2.2)	(\$6.1)	(\$7.6)		(\$0.6)	(\$0.9)	\$1.9
Visits	33,805	34,352	34,477		9,461	13,589	14,059		35,173	36,811	35,344

Sources: HSCRC cost reports and audited financial statements; Email and phone correspondence between MHCC staff and representatives for Shore Regional Health on January 15, 2015 and January 28, 2015; Information provided by HSCRC staff January 27, 2015.

Note: The reports for QAEC did not include information on contractual allowances; gross revenue reflects adjustments for contractual allowances. QAEC provided less than \$50,000 in charity care in FY 2011 and FY 2012, resulting in values rounded to zero. In FY 2013, the reporting of expenses changed for QAEC; FY 2013 includes \$1.5 million in overhead for Shore Regional Health. While legally and technically correct to include this overhead for Shore Regional Health, FY 2011 and FY 2012 include only direct costs due to the financial relationship with the University of Maryland Medical System for this period. Both GEC and BHC financial reports do not include overhead for their affiliated health care systems. Fiscal year 2011 data is not available for Bowie Health Center. GEC became rate regulated by HSCRC six months after its fiscal year 2011 began.

Table 21
Per Visit Revenue, Expenses, and Income:
Maryland Freestanding Medical Facilities, FY 2011 to FY 2013 or FY 2012 to FY2014

	GERMANTOWN				QUEEN ANNE'S				BOWIE		
	2011	2012	2013		2011	2012	2013		2012	2013	2014
Gross Revenue	\$420	\$413	\$407		\$312	\$232	\$294		\$341	\$372	\$467
Charity	\$17	\$17	\$31		\$3	\$1	\$11		\$21	\$28	\$29
Bad debt	\$29	\$63	\$68		\$9	\$18	\$6		\$51	\$56	\$61
Net Revenue	\$305	\$301	\$272		\$303	\$306	\$288		\$247	\$267	\$351
Expenses	\$332	\$329	\$344		\$534	\$448	\$539		\$263	\$292	\$296
Income	(\$10)	(\$11)	(\$55)		(\$231)	(\$142)	(\$251)		(\$16)	(\$26)	\$55

Sources: HSCRC cost reports and audited financial statements; MHCC staff analysis of freestanding medical facilities data; Email and phone correspondence between MHCC staff and representatives for Shore Regional Health on January 15, 2015 and January 28, 2015; Information provided by HSCRC staff January 27, 2015.

Notes: In FY 2013, the reporting of expenses changed for QAEC; FY 2013 includes \$1.5 million in overhead for Shore Regional Health. While legally and technically correct to include this overhead for Shore Regional Health, FY 2011 and FY 2012 include only direct costs due to the financial relationship with the University of Maryland Medical System for this period. Both GEC and BHC financial reports do not include overhead for their affiliated health care systems. In order to consistently compare the direct expenses and net income at QAEC per case across years with GEC and BHC, \$1.5 million in overhead should be removed as an expense for QAEC in FY 2013, and the expense per case and net income per case should be recalculated for FY 2013. The resulting revised expense per case in FY 2013 is \$431 and the revised income per case is (\$144).

VII. Conclusions and Recommendations

Conclusions

- **Development of a freestanding emergency center may serve to reduce crowding at its affiliated hospital's ED.**

The Germantown Emergency Center appears to have significantly reduced the volume of ED visits at Shady Grove Medical Center in the first year after it opened, and growth in ED visit volume at SGMC has moderated in subsequent years. The reduction in volume at SGMC between FY 2009 and FY 2014 is greater than the overall reduction for all Montgomery hospitals and statewide during this period.

- **The patient population using Maryland's freestanding emergency centers is admitted for inpatient hospital care at a substantially lower rate than the patient population presenting at hospital EDs.**

In FY 2014, the average rate of admission at the three FMFs was 4.5% compared to a statewide average of 14.8% for emergency departments at Maryland hospitals. Only two of 46 Maryland hospital EDs had an admission rate lower than 5.9%, which was the highest admission rate among the three FMFs in FY 2014. For Maryland hospital EDs, the highest admission rate was 22.7% in FY 2014. The transport protocols of the Maryland Institute for Emergency Medical Services Systems, which direct transport of more acutely ill or injured patients to the nearest hospital ED, bypassing closer FMFs, is undoubtedly a factor in this finding. However, the difference is also likely the result of patients' perceptions on the best locations for meeting their health care needs. The lower acuity of patients appearing at FMFs compared to hospital EDs largely explains the lower admission rate.

Hospital admissions contribute to the overall profitability of the hospital ED for the parent health system. Thus, a freestanding medical facility generating hospital admissions may contribute to the overall profitability of the parent health system. However, a new hospital payment model is evolving in Maryland that will not automatically translate service volume increases into higher revenue. A hospital will need to achieve threshold levels of quality performance and appropriate use in order to obtain financial gains from providing a higher volume of services.

- **The patient population using Maryland's freestanding emergency centers tends to be younger than the patient population using hospital EDs.**

The age distribution of the patient populations served by both FMFs and hospital EDs likely reflects both the age distribution of the population in the local service area as well as the acuity level of patients. For example, although in 2014 approximately 20% of residents living within five miles of QAEC were 65 years or older, only 13.6% of visits in FY 2014 were for this cohort. However, the proportion of patients age 65 years or older seen at QAEC is much higher than the proportion for Germantown Emergency Center (5.0%), which has only 9% of residents who are age 65 or older living within five miles.

- **The vast majority of patient visits at FMFs occurred during hours when a viable alternative for treating urgent minor problems may be available for some patients.**

Many Maryland urgent care centers operate between 8 am and 8 pm and have the appropriate resources to handle patients with urgent minor problems. In FY 2014, the percentage of patient visits at FMFs that occurred between 4 pm and midnight ranged from 54% at BHC to 60% at QAEC, and the percentage of visits during "business" hours, 8am to 4 pm, ranged from 22.2% at GEC to 33.9% at BHC. Between midnight and 8 am, all three FMFs had their lowest volume of visits. Overnight use in 2014 was only 9% of total visits at QAEC and 12% at BHC, but approached 21% at GEC.

- **Freestanding emergency centers serve a patient population with less acute needs than the patient population of hospital EDs.**

In FY 2014, approximately 45% of patients visiting Maryland hospital EDs were “high” acuity. The simple average proportion of high acuity patients visiting the three Maryland FMFs was 25%. “Moderate” acuity patients are the biggest group of FMF visitors, a simple average of just over 60% in 2014 (compared to 37% for all Maryland hospital EDs). Acuity has trended higher over time for FMFs, with most of this trend occurring in a movement from “low” acuity to moderate acuity.

- **Two of the three freestanding medical facilities in Maryland are operating at a high level of capacity use, which should minimize their cost per visit, which typically has exceeded the revenue per visit in almost all years at all three FMFs.**

The Queen Anne’s FMF has not operated at a high level of capacity use, but it is also the newest FMF in the State, opening in 2010, and also has the smallest population in its service area. Its financial performance has been worse compared to BHC and FMF, with the largest net negative income each year since it began operating.

- **Maryland’s freestanding emergency centers serve a lower proportion of Medicare patients than Maryland hospital EDs.**

On average, in FY 2014, for the three Maryland FMFs, approximately 11% of patients had Medicare as their payor compared to 27% for all Maryland hospital EDs, excluding patients who are subsequently admitted to a hospital. This difference is influenced by the age distribution of the facility service area as well as the acuity of patients.

- **Maryland freestanding emergency centers have not generated positive income from their operations, in general, when viewed as distinct, stand-alone business units.**

It is not clear that rate regulation, whose impact can only be directly observed with respect to the Germantown pilot, has improved the potential for profitability of FMFs. However, losses experienced by FMFs, when viewed in this somewhat narrow way, may not reflect positive impacts that sponsoring hospitals may attribute to the operation of FMFs, in terms of increasing use of other hospital facilities and services, differentiating the hospital or hospital system from its competitors in a positive way, increasing market share, or improving relationships with physicians.

Recommendations

In order to be successful in moderating the demand for costly emergency department use, especially by lower acuity patients, Maryland must continue to support the development of integrated care models that can reduce costs for the health care system and better meet the needs of the population. How the development of FMFs by general hospitals may support the goal of delivering emergency medical care in a less costly and more accessible form is not a question that can be easily answered based on the State’s limited experience with the two pilot facilities and the Bowie Health Center. The performance of Maryland’s freestanding emergency centers

indicates that market characteristics probably play a large role in determining how FMFs function and can be used to achieve specific objectives.

Each of the three FMFs currently in operation in Maryland was established for different stated reasons. GEC was established to alleviate overcrowding at Shady Grove; QAEC was established due to limited access to emergency services in Queen Anne's county especially in the tourist season when transport to Anne Arundel Medical Center is difficult. Bowie Health Center was established as a satellite center with the intent that it would evolve into a full-service hospital. Each facility was established without Certificate of Need review by MHCC or in the case of the Bowie Health Center, the predecessor Health Resources and Planning Commission.

In 2007, representatives from the Shady Grove Adventist Hospital, now known as the Shady Grove Medical Center, presented the Maryland Joint Committee on Health Care Delivery and Financing with their initial impression of the success of the new Germantown Emergency Center.²⁶ They noted several factors that led them to conclude that establishing a freestanding emergency facility was necessary. The stated factors included severe traffic congestion, skyrocketing population growth, emergency department overcrowding, and long distances to area hospitals. According to the representatives from SGAH, the Germantown Emergency Center was achieving its goals to improve access to emergency care for all individuals, reduce emergency department volume at the Shady Grove Adventist Hospital, and reduce the cycle time for Montgomery County Emergency Medical Services.

MHCC staff's review of GEC indicates that the establishment of GEC reduced the ED volume at SGMHC and directly improved access to emergency medical care for persons in the Germantown and Gaithersburg areas. In addition, by reducing ED crowding at SGMHC, GEC indirectly improved access to care at SGMHC's emergency department. It appears likely, based on testimony provided in a recent Certificate of Need (CON) review, that GEC also was intended to assist Adventist Health in providing emergency services to the large population base immediately north of Rockville, until northern Montgomery County was ready for a sixth general hospital, which Adventist Healthcare planned for development in the Clarksburg area. MHCC evaluated this proposal in a comparative CON review and found that the proposal from Holy Cross to develop a new hospital in Germantown was a better option for Montgomery County. The new hospital, Holy Cross Hospital-Germantown opened in October 2014 within two miles of GEC. The proximity of this hospital to GEC will likely reduce the need for services at GEC and could potentially threaten the financial feasibility of Adventist HealthCare maintaining GEC.

Improving access to emergency medical care was the primary goal for the Queen Anne's Emergency Center since Queen Anne's County does not have a hospital. The affiliated hospital nearest to QAEC is UM Shore Medical Center at Easton, located in Talbot County. However, all the hospitals in the Mid-Shore region are part of the University of Maryland Medical System. Reducing patient volume at the hospital ED in Easton was not a goal of the project. Indeed, hospital officials specifically said that the Queen Anne's Emergency Center was not expected to have an impact on the hospital or generate a profit. According to Edmond Notebaert, the

²⁶ Shady Grove Adventist Hospital Presentation to the Joint Committee on Health Care Delivery & Financing, September 6, 2007.

University of Maryland Medical System CEO at that time, “the emergency facility will never be a moneymaker.”²⁷

The Bowie Health Center was established in 1979, much earlier than the two pilot FMFs in Maryland. It appears to have been developed in lieu of a new general acute care hospital, which was authorized in the 1970s. BHC brought access to emergency medical care to the area at a time when the urgent care model of walk-in physician services was in its infancy. Until recently, BHC did not operate 24 hours per day, seven days a week, as required for FMFs. Instead, for most of its existence, it has operated in a manner that was closer to the urgent care model than the two more recent pilot facilities.

Primarily, the FMFs in Maryland were developed to increase access to services. However, some discussion has taken place between MHCC staff, hospitals, and communities about the FMF as an alternative to a small general hospital, when it is relocating to another community or is being considered for closure because maintaining or modernizing a small hospital may be excessively expensive relative to the anticipated volume of services.²⁸ These discussions have taken place within the context of CON reviews and informally. Usually these discussions involve consideration of the merits of the FMF versus the more conventional urgent care center option. The hours of operation for an FMF, 24 hours a day and seven days a week, as well as its status as a rate regulated entity, offer advantages over urgent care centers. Rate regulation allows FMFs to provide greater access to care for patients who may require financial assistance. Typically, urgent care centers require payment upfront from uninsured patients, and these centers do not need to comply with EMTALA’s requirements unless they are part of a hospital system.

Although FMFs offer advantages over urgent care centers with respect to the hours of operation and financial access, the majority of the services that are provided by FMFs are provided to patients with low and moderately acute conditions that present to the facility between 8 am and midnight. Given the proliferation of urgent care facilities that are capable of handling most low to moderate acuity conditions and that, in Maryland, generally operate from 8 am to 8 pm, this pattern of use of FMFs suggests that FMFs may be a more costly vehicle for expanding access and availability of emergency medical care when a combination of general hospital ED facilities and lower cost urgent care centers are nearby. This is especially true if the urgent care sector expands to include more centers that have extensive hours of operation. For example, the Righttime Medical Care centers operate from 7 am to midnight. Kaiser Permanente has also recently developed large outpatient centers in Maryland for its enrolled HMO members that integrate urgent care, 24 hours a day and seven days a week, and services such as high-end diagnostic imaging, that bring this urgent care model closer to the FMF model. These centers also may have 23-hour observation units. Kaiser is now operating these types of facilities in

²⁷ Talbot Preservation Alliance, Staff Writer Jack Shaum. *UMMS wants to put ER in QA’s*. http://www.talbotpreservation.org/includes/070306%20UMMS%20ER_1174055450_918_1.pdf

²⁸ An option that would more effectively preserve the role of an underutilized hospital as more than just a provider of emergency services is converting it to a “limited service hospital” that provides outpatient, emergency, and other services 24/7 but no inpatient services. This option was established in Maryland law in 1999, and it can be authorized through the issuance of a CON exemption. However, it has not been used in Maryland to date.

Gaithersburg (Montgomery County), Halethorpe (Baltimore County), and Largo (Prince George's County).

The impact of the Affordable Care Act on payer mix will be important to consider. As noted previously, HSCRC discharge and hospital outpatient data sets do not directly flag insurance status, rather uninsured is implied if the patient or the patient's spokesperson report the patient will self-pay. Although Maryland specific estimates on the reduction in the uninsured are not available, MHCC estimates that approximately 50 percent of the uninsured will gain coverage either through private coverage or via Medicaid. This estimate in the reduction of uninsured is consistent with the experience in Massachusetts after the launch of its state health coverage initiative in 2006. It is noteworthy that use of EDs did not expand, even though the percentage of patients that were insured grew.²⁹ Expanded coverage would increase profitably due to a more favorable payer mix and would likely increase utilization, especially in areas of the state where access to primary care is limited. Expanded utilization would likely also contribute to increased profitability.

Even though the use of a freestanding medical facility for a low acuity condition is a less expensive option than using a hospital emergency department, it is a more expensive option for treatment of a low acuity condition, as compared to a patient's routine source of care which would typically be a primary care practice, a multi-specialty center, or a community health center. These sites would also be better equipped to support ongoing treatment after the visit. Urgent care and retail health clinics might also be more cost-effective alternatives and typically offer weekend and extended hours during the week.

Regardless of where emergency care is rendered, patients in Maryland can be assured that information will be appropriately shared with primary care providers and emergency department personnel. The Maryland health information exchange now enables information exchange to providers in hospital emergency departments and FMFs. Primary care providers may also receive notifications when a patient visits a hospital ED or an FMF. MHCC is working with CRISP, the State designated HIE, to expand the same opportunity for information sharing to urgent care and retail clinics. The ability of the urgent care centers and retail clinics to support continuity of care is an issue worthy of further study.

In 2015, MHCC will develop regulatory policies to assess the need, cost-effectiveness, impact, and viability of further FMF development in Maryland. After July 1, 2015 additional FMFs may be developed, if approved through the CON review process. The pilot facility experience suggests that the way in which the need for these types of facilities is defined by their hospital sponsors will vary depending on the particular market conditions in which the sponsor finds itself. While it is likely that most proposals for new FMF development may be located in suburban and exurban areas of the State where travel time issues related to traffic congestion are of paramount concern, these are also the areas of the State that often have overlapping service areas with multiple alternative hospital EDs. Under these circumstances, the rationale for developing this type of facility to handle what are largely non-urgent to moderately acute patient

²⁹ Chen Christopher, Scheffler Gabriel, and Chandra Amitabh, "Massachusetts' Health Care Reform and Emergency Department Utilization," *The New England Journal of Medicine*, published on September 7, 2011, at NEJM.org.

encounters is dubious. Although these locations will tend to have large populations that can support a higher level of operational scale, and the FMF experience indicates that this will improve the chances for viable operation, it is the rural areas of the State where such facilities are likely to provide the greatest improvement in access to emergency medical care. However, in these rural areas, an FMF has the least chance of ever becoming self-sustaining because of its small operating base.

In developing new regulatory policies and standards, it will be important for MHCC to require a hospital to explain why the extension of mostly urgent and some emergent medical care beyond the hospital's ED cannot be better accomplished with less expensive models of unscheduled care delivery. MHCC should require a hospital to justify the development of an FMF by showing that it will serve as a resource that improves the health status of the population in its likely service area. An FMF can serve as a convenient entry point for patients to have their short term diagnosis and treatment needs met. However, a hospital sponsoring an FMF should be able to show that the FMF will be a gateway for patients to be integrated within a system of regular primary care and chronic disease management that has the potential to reduce the need for episodic and expensive visits to an FMF or hospital ED. Although it is unlikely that this role will significantly alter patterns of mortality and morbidity in the population as compared to the traditional hospital ED setting or less expensive outpatient settings, this regulatory approach is necessary for promoting an efficient and cost-effective health care system.

Appendix 1

COMAR 10.07.08:

Licensing Requirements for Freestanding Medical Facilities in Maryland

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Subtitle 07 HOSPITALS
Chapter 08 Freestanding Medical Facilities
Authority: Health-General Article, §2-104 and Subtitle 19-3A, Annotated Code of Maryland

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

- (1) "Accredited hospital" means a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- (2) "ACEP" means the American College of Emergency Physicians.
- (3) "Affiliated hospital" means a hospital that operates and provides ancillary and support services to the freestanding medical facility.
- (4) "Certified medical radiation technologist" means an individual who is certified by the Board of Physicians to practice medical radiation technology in this State.
- (5) "Credentialing process" means the process by which a hospital:
 - (a) Verifies qualifications of a physician;
 - (b) Delineates clinical privileges of a physician; and
 - (c) Monitors performance of a physician.
- (6) "Department" means the Department of Health and Mental Hygiene.
- (7) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, psychiatric disturbances, and symptoms of substance abuse such that the absence of immediate medical attention could result in:
 - (a) Placing the health of the individual in serious jeopardy;
 - (b) Placing the health of a pregnant woman or unborn child in serious jeopardy;
 - (c) Serious impairment to any bodily function;
 - (d) Serious dysfunction of any bodily organ or part; or
 - (e) With respect to a pregnant woman who is having contractions:
 - (i) Inadequate time to effect a safe transfer to another hospital before delivery; or
 - (ii) The transfer posing a threat to the health or safety of the woman or the unborn child.
- (8) "Freestanding medical facility" means a facility:
 - (a) In which medical and health services are provided;
 - (b) That is physically separated from a hospital or hospital grounds; and
 - (c) That is an administrative part of a hospital or related institution.
- (9) "Hospital" means an institution that:
 - (a) Has a group of at least five physicians who are organized as a medical staff for the institution;
 - (b) Maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for two or more unrelated individuals; and
 - (c) Admits or retains the individuals for overnight care.

(10) "Joint Commission on Accreditation of Healthcare Organizations" means the voluntary national healthcare accreditation service recognized for Medicare certification purposes by Public Law 89-97.

(11) "License" means a document issued by the Secretary to operate a freestanding emergency medical facility in this State.

(12) "Licensed independent practitioner" means any individual permitted by law and by the facility to provide care and services without direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

(13) "Physician" means an individual who is licensed by the Board of Physicians to practice medicine in this State.

(14) "Registered nurse" means an individual who is licensed by the Board of Nursing to practice registered nursing in this State.

(15) "Related institution" means a facility as defined under Health-General Article, §19-301(o), Annotated Code of Maryland.

(16) "Secretary" means the Secretary of Health and Mental Hygiene.

.02 Incorporation by Reference.

A. In this chapter, the following documents are incorporated by reference.

B. Documents Incorporated.

(1) Interhospital Transfer Guidelines Manual; Maryland Institute for Emergency Medical Services Systems, Baltimore, Maryland (January 2002).

(2) ACEP Policy Statement: Emergency Department Planning and Resources Guidelines (June 2004), American College of Emergency Physicians, PO Box 619911, Dallas, Texas 75261-9911.

(3) Guidelines for Design and Construction of Hospital and Healthcare Facilities, 2001 Edition, American Institute of Architects, 1735 New York Avenue, N.W., Washington D.C. 20006, which is incorporated in COMAR 10.07.01.03.

(4) Hospital Accreditation Standards, 2006 Edition, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd, Oakbrook Terrace, Illinois 60181, which is incorporated in COMAR 10.07.01.09.

(5) U.S. Centers for Disease Control and Prevention Guidelines for Standard Precautions and the federal Occupational Safety and Health Administration/Maryland Occupational Safety and Health, Bloodborne Pathogen Standard 29 CFR §1910.1030 which is incorporated by reference in COMAR 09.12.31.

(6) The Maryland State Fire Prevention Code, which is incorporated by reference in COMAR 29.06.01.

.03 Restrictions.

A freestanding medical facility may not use the name "emergency room", "emergency department", or "hospital" in its title or advertisements or on any signage.

.04 Licensure Application Procedure.

A. A hospital may not establish, operate, or continue to operate an existing freestanding medical facility without first obtaining a license from the Secretary.

- B. A hospital desiring to establish a freestanding medical facility shall apply to the Department for initial licensure on a form provided by the Secretary.
- C. The application shall state the name of the affiliated accredited hospital.
- D. The application shall be accompanied by a nonrefundable 3-year license fee of \$3,000.
- E. The Secretary shall issue a license to a freestanding medical facility for a term of 3 years if the facility complies with all licensing requirements.

.05 Renewal of License.

- A. A licensee shall file an application for license renewal with the Secretary on a form provided by the Secretary.
- B. A licensed freestanding medical facility shall apply for licensure within 60 days of the expiration date of its current license.
- C. The application for license renewal shall be accompanied by a nonrefundable 3-year license renewal fee of \$3,000.

.06 Inspections.

- A. A freestanding medical facility shall be open to inspection at all times by the Department for annual licensure surveys, revisit surveys, and complaint investigations.
- B. Licensure Standards. When conducting a licensure or complaint survey, the Department shall use this chapter as well as the:
 - (1) Joint Commission on Accreditation of Healthcare Organization, 2006 Hospital Accreditation Standards;
 - (2) COMAR 10.07.06;
 - (3) COMAR 10.07.01.24, .26 and .33; and
 - (4) ACEP Policy Statement: Emergency Department Planning and Resources Guidelines.
- C. Responsibility of the Freestanding Medical Facility. The facility shall make the following documents available for review by the Department:
 - (1) Policies and procedures;
 - (2) Minutes of committee meetings; and
 - (3) Data and documentation related to oversight of the freestanding medical facility at the affiliated hospital.

.07 Waiver.

- A. Facilities that are providing services on or before February 12, 2007, but do not meet all requirements of this chapter, may request a waiver of specific requirements from the Department.
- B. All other freestanding medical facilities seeking a waiver from this chapter shall submit a request to the Department including the rationale for the waiver and alternatives to the requirement based on clinical and technical advances.
- C. In its request, the facility shall demonstrate that a waiver of the requirement would:
 - (1) Not pose a threat to patients or the provision of services; and
 - (2) Be a financial hardship for the facility to comply with that requirement.
- D. The Department shall review the request for a waiver and notify the freestanding medical facility of its determination.

.08 Affiliated Hospitals.

A. The freestanding medical facility shall be reviewed under the affiliated hospital's accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

B. The governing body of the affiliated hospital shall provide administrative and clinical oversight for the care and services provided by the freestanding medical facility. Services of the facility shall be reviewed and monitored consistent with the hospital's bylaws, including but not limited to:

- (1) Patient safety;
- (2) Peer review;
- (3) Medical staff;
- (4) Risk management; and
- (5) Quality improvement.

C. The Department may issue a waiver for the requirement for accreditation if the affiliated hospital is not accredited or if the hospital is actively seeking accreditation.

.09 Treatment of Patients.

Regardless of a patient's medical condition, insurance status, or ability to pay, the freestanding medical facility shall provide stabilizing treatment to a patient presenting with an emergency medical condition.

.10 Personnel.

A. Administrative Director. The freestanding medical facility shall have a full-time administrative director who:

- (1) Acts as a liaison with the affiliated hospital;
- (2) Directs the daily operation of the facility; and
- (3) Ensures that employees are capable of providing:
 - (a) Resuscitation;
 - (b) Stabilization;
 - (c) Timely triage; and
 - (d) Appropriate transfer of all patients; and
- (4) Ensures that there is an organized and structured patient safety and quality improvement program to monitor and improve patient care.

B. Medical Director. The facility shall have a Medical Director who is:

- (1) A licensed physician; and
- (2) Board certified or Board eligible in Emergency Medicine by the:
 - (a) American College of Emergency Physicians;
 - (b) American Board of Emergency Medicine; or
 - (c) American Osteopathic Board of Emergency Medicine.

C. The Medical Director shall provide clinical oversight of the freestanding medical facility. 81

D. Other Personnel. The freestanding medical facility shall be staffed at all times with a:

- (1) Minimum of one physician who is trained in emergency medicine;
- (2) Sufficient number of registered nurses and other professionals to provide advanced life support;
- (3) Certified medical radiation technologist; and
- (4) Laboratory technician.

E. A freestanding medical facility shall be staffed during all hours of operation by licensed independent practitioners, nurses, and ancillary health care professionals with the certification, experience, competencies, and skills necessary for providing basic and advanced life support for children and adults.

F. Credentialing. Physicians and other licensed independent practitioners shall be credentialed consistent with COMAR 10.07.01.24.

G. The facility shall assess its staffing pattern on a regular basis. Staffing patterns shall accommodate the potential for the unexpected arrival of additional patients. The facility shall have a plan for the provision of additional licensed independent practitioners and nurses in times of acute overload.

.11 Quality Assurance.

A. The freestanding medical facility shall develop and implement a quality assurance program.

B. The quality assurance program shall have a quality management process that:

- (1) Is multidisciplinary;
- (2) Is integrated into the hospital's overall quality management program that is reported to the hospital's governing body;
- (3) Has a structure to ensure that defined program outcomes and performance measures are developed and monitored regularly;
- (4) Maintains sufficient documentation to:
 - (a) Verify problems;
 - (b) Identify opportunities for improvement; and
 - (c) Show corrective actions taken and resolution of problems;
- (5) Includes review of morbidity and mortality; and
- (6) Evaluates medical care, nursing care, utilization review, tissue review, and pre-hospital care.

.12 Laboratory Services.

A. The freestanding medical facility shall have on-site laboratory services that are available during the facility's hours of operation.

B. Laboratory Licensure Standards. The facility's laboratory services shall be licensed consistent with:

- (1) COMAR 10.10.01;
- (2) COMAR 10.10.02;
- (3) COMAR 10.10.03;
- (4) COMAR 10.10.04;
- (5) COMAR 10.10.05;
- (6) COMAR 10.10.06;
- (7) COMAR 10.10.07; and
- (8) COMAR 10.10.08.

C. Laboratory services shall include the "Suggested Laboratory Capabilities", ACEP Policy Statement: Emergency Department Planning and Resources Guidelines, Page 13.

.13 Radiology Services.

A. The freestanding medical facility's radiology services shall comply with all State and federal requirements for licensure.

B. Radiology services shall be available on site at all times that the facility is open for business consistent with "Radiological, Imaging, and Other Diagnostic Services", ACEP Policy Statement: Emergency Department Planning and Resources Guidelines, Page 12, except for the sections related to Nuclear Medicine, Radiographic Services, and Vascular/flow Studies including impedance plethysmography.

.14 Pharmacy Services.

A. Pharmacy services for freestanding medical facility patients may be provided by:

- (1) The facility's affiliated hospital; or
- (2) A contracted pharmacy.

B. The freestanding medical facility that does not have 24-hour a day, 7-day a week outpatient pharmacy services,

shall provide its patients with a list of community pharmacies that offer service 24-hours per day.

C. The facility's pharmacy services shall be provided and operated consistent with all applicable State and federal laws.

D. The freestanding medical facility shall maintain a supply of medications consistent with the "Suggested Pharmacological and Therapeutic Drugs for Emergency Departments", ACEP Policy Statement Emergency Department Planning and Resources Guidelines, Page 11.

E. The facility shall ensure that all drugs and pharmaceuticals are stored securely and maintained within the acceptable level of humidity and temperature.

F. Data and other information about quality oversight of the pharmacy services shall be available to the Department for review and monitoring.

.15 Access to Emergency Medical Services.

An emergency medical facility shall meet the requirements of the Maryland Institute for Emergency Medical Services Systems to be eligible to accept patients through the Emergency Medical System.

.16 Transfer of Patients.

A. The freestanding medical facility shall have pre-arranged transfer agreements with facilities that are capable of providing definitive care appropriate for the nature and severity of the patient's illness or injury.

B. Patient transfers shall be consistent with the Interhospital Transfer Guidelines published by the Maryland Institute for Emergency Medical Services System.

C. When transfer by ambulance is medically necessary the facility shall transfer the patient via:

- (1) A hospital owned and operated ambulance service;
- (2) A contracted ambulance service; or
- (3) An ambulance service through an agreement with the local emergency medical system (EMS) jurisdictional program.

D. The level of care and medical interventions provided by an ambulance during transfer shall be appropriate for the patient's condition.

E. Before transfer, the patient shall:

- (1) Be assessed by a physician or licensed independent practitioner; and
- (2) Receive stabilizing medical treatment consistent with that of the freestanding medical facility's ability to treat.

F. The freestanding medical facility shall provide the emergency medical system and the receiving facility with the patient's medical records necessary for ongoing care, including:

- (1) All treatment provided to the patient;
- (2) Medications administered to the patient;
- (3) Diagnostic procedures performed for the patient; and
- (4) The patient's response to the care at the time of transfer.

.17 Medical Records.

A. The freestanding medical facility shall ensure that staff members develop a legible and appropriate medical record for each patient who visits the facility for treatment.

B. Security and Disclosure of Medical Information. The freestanding medical facility shall:

- (1) Maintain records in a secure manner that protects the confidentiality of patient information at all times;
- (2) Develop and implement policies and procedures for disclosure of patient medical records and patient access to their medical records, including the costs for retrieving and copying records as defined in Health-General Article, §§4-301— 4-309, Annotated Code of Maryland; and
- (3) Make medical records available to emergency medical services agencies for outcome data as directed by the Maryland Institute for Emergency Medical Services System.

C. Retention. The medical record shall be retained as required by all federal and State laws and regulations and shall be made available promptly to the freestanding medical facility staff.

.18 Nourishing Snacks.

A freestanding medical facility shall maintain a supply of nourishing snacks for patients who may require them. The facility shall provide appropriate storage facilities, including refrigeration for the nourishing snacks.

.19 Infection Control.

The freestanding medical facility shall comply with the U.S. Centers for Disease Control and Prevention guidelines for standard precautions and the federal Occupational Safety and Health Administration/Maryland Occupational Safety and Health, Bloodborne Pathogen Standard, except in a life-threatening emergency in which compliance is not feasible or practicable.

.20 Equipment and Supplies.

The freestanding medical facility shall have equipment and supplies available consistent with the "Suggested Equipment and Supplies for Emergency Departments," ACEP Policy Statement: Emergency Department Planning and Resources Guidelines, pages 7-10.

.21 Physical Environment.

A. Construction and Zoning. The freestanding medical facility shall comply with the following construction and zoning requirements:

- (1) All federal, State, and local building, construction and zoning laws; and
- (2) "Guidelines for Design and Construction of Hospital and Healthcare Facilities, (2001 Edition)," Section 9.6 Freestanding Emergency Facility and other applicable sections.

B. Fire Safety.

(1) The facility shall comply with the Maryland State Fire Prevention Code and applicable local fire prevention codes that are in effect at the time of plans review and construction.

(2) The local fire authority for the proposed facility shall review construction plans and conduct an initial inspection to verify compliance with fire safety requirements before use and occupancy.

(3) An annual fire inspection of the facility is required for license renewal.

C. Housekeeping.

(1) The freestanding medical facility shall be clean and maintained in good repair at all times.

(2) The facility shall employ sufficient staff to provide housekeeping and maintenance services, or the services may be provided under a contractual arrangement.

(3) The facility shall be maintained in a manner that is safe and free of pests or other hazards.

D. Equipment Maintenance.

(1) The freestanding medical facility shall have a preventive maintenance program for all facility systems and equipment.

(2) The facility shall maintain records of preventive maintenance performed and of all service repairs.

(3) Appropriately trained staff employed by the facility or under contractual arrangements shall perform maintenance of clinical equipment.

E. All entrances, including ambulance entrances, shall be clearly marked and accessible at all times.

F. There shall be a sheltered area for off-loading patients from ambulances.

G. The facility shall store and dispose of trash and medical waste consistent with all federal and State laws and regulations.

.22 Emergency Preparedness.

The freestanding medical facility shall develop an emergency preparedness plan to address internal and external emergencies. The emergency plan shall identify the manner by which the facility will interface with local emergency services and the affiliated hospital in the event of a major disaster.

.23 Emergency Suspension.

A. The Secretary may immediately suspend a license on finding that the public health, safety, or welfare imperatively requires emergency action.

B. Notice of Emergency Suspension. The Department shall deliver a written notice to the licensee:

(1) Informing the licensee of the emergency suspension;

(2) Giving the reasons for the action and the regulation or regulations with which the licensee has failed to comply that forms the basis for the emergency suspension; and

(3) Notifying the licensee of its right to request a hearing and to be represented by counsel.

C. The filing of a hearing request does not stay the emergency action.

D. Suspension of License. When a license is suspended by emergency action, the licensee shall:

(1) Immediately return the license to the Department;

(2) Stop providing services immediately; and

(3) Notify patients or the patients' representatives about the suspension and make every reasonable effort to assist them in making other arrangements for services.

E. A person aggrieved by the action of the Secretary under this regulation may appeal the Secretary's action by filing a request for a hearing consistent with Regulation .25 this chapter.

F. Show Cause Hearing.

(1) In addition to the right to request a hearing consistent with Regulation .25 of this chapter, a person aggrieved by the action of the Secretary under this regulation shall be given the opportunity for a hearing to show cause why the Department should lift the summary suspension.

(2) The show cause hearing shall be a nonevidentiary hearing to provide the parties with an opportunity for oral argument on the summary suspension.

(3) Show Cause Hearing Procedures. The show cause hearing shall be conducted before the Secretary or a designee of the Secretary, who:

(a) Shall determine procedural issues;

(b) May impose reasonable time limits on each party's oral argument; and

(c) Shall make rulings reasonably necessary to facilitate the effective and efficient operation of the show cause hearing.

(4) Results of a Show Cause Hearing. At the conclusion of the show cause hearing, the Secretary or the Secretary's designee may:

(a) Affirm the order of summary suspension;

(b) Rescind the order of summary suspension;

(c) Enter into a consent order; or

(d) Enter into an interim order warranted by the circumstances of the case, including one providing for a stay of the summary suspension subject to certain conditions.

(5) After the show cause hearing, if the Secretary or the Secretary's designee decides to continue the summary suspension, the person aggrieved by the decision may request an evidentiary hearing before the Office of Administrative Hearings consistent with Regulation .25 of this chapter.

.24 Sanctions.

A. In addition to other penalties available under State law, the Department may impose sanctions against a freestanding medical facility that fails to comply with Health-General Article, Subtitle 3A, Annotated Code of Maryland, or the regulations of this chapter. The sanctions include:

(1) A civil penalty not to exceed \$10,000; 87

(2) Restrictions on the operation of the freestanding medical facility;

(3) A directed plan of correction; and

(4) Suspension or revocation of the freestanding medical facility's license.

B. Except as otherwise provided under the Administrative Procedure Act, State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland, before the Department may impose any sanctions under §A of this regulation, the Department shall provide the freestanding medical facility notice and an opportunity for a hearing and judicial review under the Administrative Procedure Act.

C. Before the Department imposes a directed plan of correction, the Department shall give the freestanding medical facility notice and the opportunity for a prompt informal hearing with the Director of the Office of Health Care Quality.

.25 Hearings.

A. The licensee shall file a request for a hearing with the Office of Administrative Hearings, with a copy to the Office of Health Care Quality of the Department, not later than 30 days after receipt of notice of the Secretary's action. The request shall include a copy of the Secretary's action.

B. A hearing requested under this chapter shall be conducted consistent with State Government Article, §10-201 et seq., Annotated Code of Maryland, and COMAR 28.02.01 and 10.01.03.

C. The burden of proof is as set forth in COMAR 10.01.03.28.

D. Unless otherwise stated in this chapter, the Office of Administrative Hearings shall issue a proposed decision within the time frames set forth in COMAR 28.02.01.

E. The aggrieved person may file exceptions as set forth in COMAR 10.01.03.35.

F. The Secretary shall issue a final decision consistent with COMAR 10.01.03.35.

10.07.08.9999

Administrative History

Effective date: February 12, 2007 (34:3 Md. R. 297)

Appendix 2

Timeline: Freestanding Medical Facility Pilot Projects

June 10, 2004: Maryland Health Care Commission denies certificate of need application filed by Shady Grove Medical Center (Adventist Health Care) seeking to establish a five-bed hospital and emergency department in Germantown, Montgomery County.

February 1, 2005: During the 2005 session of the Maryland General Assembly, Ch. 549 and 550, Acts of 2005 became law creating a pilot project in Montgomery County, Maryland to study the provision of emergency health care services in a hospital-affiliated, freestanding facility. This law, Freestanding Medical Facilities—Licensing and Pilot Project became effective on June 1, 2005.

June 1, 2005: An amended HB 426 Freestanding Medical Facilities-Licensing and Pilot Project becomes effective. HB 426 Hospital-Emergency Department Services-Satellite Locations introduced. The legislation, as originally filed, would exempt from certificate of need requirements for the establishment of certain “satellite” emergency department services, and would have amended the definitions of “hospital” and “hospital services.” The original bills specifically provided that services provided at a satellite location would be considered part of the hospital for rate-setting purposes. The bill, as adopted, did not change the definition of “hospital” or “hospital services” and provided that various categories of payers would pay rates in contracts negotiated with the facility.

October 1, 2005: Progress Report in Obtaining Provider-Based Status for Freestanding Medical Facility Pilot Project Operated by AHC filed with the Chairman of the Senate Finance and House Health and Government Operations Committees. The original timeframe established in the legislation for the Commission’s study and development of recommendations regarding the review process for additional freestanding medical facilities assumed that the Montgomery County pilot project would be able to begin operations soon after the close of the 2005 General Assembly session. For a number of reasons, the opening of the Montgomery County pilot project, the Germantown Emergency Center, was delayed until August 2006. Given the delayed opening of the Germantown Emergency Center, the Commission faced the challenge of having insufficient data to serve as a basis for making recommendations to the General Assembly regarding the operations, utilization, and financing of the pilot project and for proposing regulations to establish a review process to guide approval of additional facilities seeking licensure as freestanding medical facilities. The Executive Director of the Commission wrote the Chairmen of the Senate Finance and House Health and Government Operations Committees regarding this issue in October 2007. In that letter, Dr. Cowdry indicated that the Commission would provide a report to the General Assembly on or before December 31, 2007, as required by law. This report provided an interim review of available data on the operations and utilization of the Germantown Emergency Center.

July 27, 2006: Shady Grove Medical Center submitted a provider-based attestation to CMS for the Shady Grove Medical Center Emergency Center at Germantown (Germantown Emergency Center). August 7, 2006 Germantown Emergency Center opens.

October 23, 2006: COMAR 10.24.06: Data Reporting by Freestanding Medical Facilities becomes effective (33:21 Md.R. 1675). These regulations require a freestanding medical facility

to report data requested by the Maryland Health Care Commission for planning and analysis purposes.

November 6, 2006: Shady Grove Medical Center notified that CMS denied the hospital's request for provider-based status for its Germantown Emergency Center.

December 28, 2006: Shady Grove Medical Center filed a request that CMS reconsider its denial of provider-based status for the Germantown Emergency Center. The request was denied March 1, 2007 and Shady Grove Medical Center appealed to the U.S. Department of Health and Human Services (DHHS) Departmental Appeal Board, Civil Remedies Division.

February 12, 2007: COMAR 10.07.08: Freestanding Medical Facilities becomes effective(34:3 Md.R. 297). These Office of Health Care Quality regulations provide licensure requirements for freestanding medical facilities.

May 17, 2007: In 2007, the General Assembly adopted legislation, SB 750 Queen Anne's County-Health Care Facilities Regulation-Licensing of Freestanding Medical Facilities (Chapter 574), adding a second pilot project site in Queen Anne's County, Maryland. The bill adding the second pilot project site was adopted as an emergency measure and became effective May 17, 2007.

June 13, 2007: Bowie Health Center licensed as a Freestanding Medical Facility. December 31, 2007 Interim Report on the Operations, Utilization, and Financing of Freestanding Medical Facilities-Required Under HB 426 (Chapters 549 and 550, Acts of 2005)-Freestanding Medical Facilities-Licensing and Pilot Project submitted by the Maryland Health Care Commission to the Chairmen of the Senate Finance and the House Health and Government Operations Committees.

May 8, 2008 Administrative Law Judge (ALJ) at the DHHS Appeals Board, Civil Remedies Division, reverses the CMS ruling that denied provider-based status to the Germantown Emergency Center. CMS later appeals ALJ's decision to the Appellate Division of the DHHS Departmental Appeals Board.

December 31, 2008: DHHS Appellate Division, Departmental Appeals Board, reverses ALJ, and rules that CMS properly denied provider-based status to the Germantown Emergency Center.

March 6, 2009: Shady Grove Medical Center files appeal/complaint in U.S. District Court for Maryland.

August 17, 2009: Groundbreaking for Queen Anne's Emergency Center.

February 18, 2010: Report on the Operations, Utilization, and Financing of Freestanding Medical Facilities-Required Under HB 426 (Chapters 549 and 550, Acts of 2005)-Freestanding Medical Facilities-Licensing and Pilot Project submitted by the Maryland Health Care Commission to the Chairmen of the Senate Finance and the House Health and Government Operations Committees.

June 1, 2010: effective date of Senate Bill 593/ House Bill 699, which required the State Health Services Cost Review Commission (HSCRC) to set rates for services provided at: a freestanding medical facility licensed prior to July 1, 2007; a freestanding medical facility authorized prior to January 1, 2008; a freestanding medical facility issued a certificate of need (CON) by the MHCC after July 1, 2015.

Appendix 3

Maryland Laws Regarding Freestanding Medical Facilities

West's Annotated Code of Maryland

Health--General

Title 15. Assistance Programs (Refs & Annos)

Subtitle 1. Medical and Pharmacy Assistance Programs (Refs & Annos)

Effective: May 2, 2013

MD Code, Health - General, § 15-105

§ 15-105. Reimbursement rules and regulations

...

Freestanding medical facility

(g) The Program shall pay the rates set by the Health Services Cost Review Commission for hospital services, as defined in § 19-201 of this article, provided at:

- (1) A freestanding medical facility pilot project authorized under § 19-3A-07 of this article prior to January 1, 2008; and
- (2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015.

West's Annotated Code of Maryland

Health--General

Title 19. Health Care Facilities (Refs & Annos)

Subtitle 1. Health Care Planning and Systems Regulation (Refs & Annos)

Part II. Health Planning and Development

Effective: October 1, 2014

MD Code, Health - General, § 19-114

§ 19-114. Definitions

In general

(a) In this Part II of this subtitle the following words have the meanings indicated.

...

Health care facility

(d)(1) "Health care facility" means:

...

(viii) A freestanding medical facility, as defined in § 19-3A-01 of this title;

West's Annotated Code of Maryland

Health--General

Title 19. Health Care Facilities (Refs & Annos)

Subtitle 2. Health Services Cost Review Commission (Refs & Annos)

Part I. Definitions; General Provisions

Effective: June 1, 2010

MD Code, Health - General, § 19-201

§ 19-201. Definitions

In general

(a) In this subtitle the following words have the meanings indicated.

Commission

(b) "Commission" means the State Health Services Cost Review Commission.

...

Hospital services

(d)(1) "Hospital services" means:

(i) Inpatient hospital services as enumerated in Medicare Regulation 42 C.F.R. § 409.10, as amended;

(ii) Emergency services, including services provided at:

1. Freestanding medical facility pilot projects authorized under Subtitle 3A of this title prior to January 1, 2008; and

2. A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015;

....

West's Annotated Code of Maryland

Health--General

Title 19. Health Care Facilities (Refs & Annos)

Subtitle 2. Health Services Cost Review Commission (Refs & Annos)

Part II. Health Care Facility Rate Setting

Effective: April 12, 2011

MD Code, Health - General, § 19-211

§ 19-211. Jurisdiction of Commission

...

Freestanding medical facilities

(c) The Commission shall set rates for hospital services provided at:

(1) A freestanding medical facility pilot project authorized under Subtitle 3A of this title prior to January 1, 2008; and

(2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015.

...

West's Annotated Code of Maryland**Health--General**

Title 19. Health Care Facilities (Refs & Annos)

Subtitle 3A. Freestanding Medical Facilities (Refs & Annos)

Effective: June 1, 2010

MD Code, Health - General, § 19-3A-03**§ 19-3A-03. Issuance of certificate****In general**

(a) The Department shall issue a license to a freestanding medical facility that:

(1) Meets the licensure requirements under this subtitle; and

(2) After July 1, 2015, receives a certificate of need from the Maryland Health Care Commission issued under § 19-120 of this title.

Use of emergency language

(b) A freestanding medical facility that uses in its title or advertising the word “emergency” or other language indicating to the public that medical treatment for immediately life-threatening medical conditions exist at that facility shall be licensed by the Department before it may operate in this State.

Maryland Health Care Commission

(c) Notwithstanding subsection (a)(2) of this section, the Department may not require a freestanding medical facility pilot project to be approved by the Maryland Health Care Commission as a condition of licensure.

West's Annotated Code of Maryland**Health--General**

Title 19. Health Care Facilities (Refs & Annos)

Subtitle 3A. Freestanding Medical Facilities (Refs & Annos)

Effective: June 1, 2010

MD Code, Health - General, § 19-3A-07

§ 19-3A-07. Freestanding medical facility pilot project

In general

(a) There are two freestanding medical facility pilot projects that shall operate in two jurisdictions in the State.

Award of license

(b) The Department shall issue a freestanding medical facility license to:

(1) One freestanding medical facility pilot project if:

- (i) The freestanding medical facility pilot project is established by, and will operate administratively as part of, an acute care general hospital;
- (ii) The acute care general hospital is part of a merged asset system with all of its existing Maryland acute care general hospitals located in a single jurisdiction;
- (iii) There are not more than 5 acute care general hospitals in the jurisdiction;
- (iv) One or more of the existing acute care general hospitals in the merged asset system has an emergency department volume of 75,000 or more visits for the 12 months ending June 30, 2004;
- (v) The freestanding medical facility pilot project will operate in Montgomery County;
- (vi) The capital expenditure to implement the freestanding medical facility pilot project otherwise meets the requirements of § 19-120(k)(6)(viii) of this title; and
- (vii) The freestanding medical facility pilot project meets the requirements under § 19-3A-02(b) of this subtitle; and

(2) One freestanding medical facility pilot project if:

- (i) The freestanding medical facility pilot project is established by, and will operate administratively as part of, an acute care general hospital located in Talbot County;
- (ii) The freestanding medical facility pilot project will operate in Queen Anne's County;
- (iii) The capital expenditure to implement the freestanding medical facility pilot project otherwise meets the requirements of § 19-120(k)(6)(viii) of this title; and
- (iv) The freestanding medical facility pilot project meets the requirements under § 19-3A-02(b) of this subtitle.

Duty to provide information

(c)(1) A freestanding medical facility pilot project shall provide to the Maryland Health Care Commission information, as specified by the Commission, on the configuration, location, operation, and utilization, including patient-level utilization, of the pilot project.

(2) A certificate of need is not required for a freestanding medical facility pilot project.

Application of Subtitle

(d) The provisions of §§ 19-3A-01 through 19-3A-06 of this subtitle shall apply to a freestanding medical facility pilot project.

West's Annotated Code of Maryland

Health--General

Title 19. Health Care Facilities (Refs & Annos)

Subtitle 3A. Freestanding Medical Facilities (Refs & Annos)

Effective: June 1, 2010

MD Code, Health - General, § 19-3A-08

§ 19-3A-08. Rates paid to freestanding medical facilities

Application of section

(a) This section applies to all payors subject to the rate-setting authority of the Health Services Cost Review Commission, including:

- (1) Insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery individual, group, or blanket health insurance policies and contracts in the State;
- (2) Managed care organizations, as defined in [§ 15-101](#) of this article; and
- (3) The Maryland Medical Assistance Program established under Title 15, Subtitle 1 of this article.

Freestanding medical facilities

(b) A payor subject to this section shall pay rates set by the Health Services Cost Review Commission under Subtitle 2 of this title for hospital services provided at:

- (1) A freestanding medical facility pilot project authorized under this subtitle prior to January 1, 2008; and
 - (2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015.
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Uncodified language from Chapter 699 (HB 600/ SB593, 2010 Regular Session)

SECTION 2. AND BE IT FURTHER ENACTED, That it is the intent of the General Assembly that emergency services provided by a freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015, and by freestanding medical facility pilot projects authorized under § 19–3A–07 of the Health – General Article, as enacted by Section 1 of this Act, prior to January 1, 2008, be considered hospital services by all payors, including the federal Medicare program.

SECTION 3. AND BE IT FURTHER ENACTED, That, on or before October 1, 2010, the Health Services Cost Review Commission shall report to the General Assembly, in accordance with § 2–1246 of the State Government Article, on the rates that the Commission has established for freestanding medical facility pilot projects under this Act and the methodology for establishing those rates.

SECTION 4. AND BE IT FURTHER ENACTED, That:

(a) (1) The Maryland Health Care Commission, in consultation with the Health Services Cost Review Commission, shall conduct a study of the effect of the rates established for freestanding medical facility pilot projects by the Health Services Cost Review Commission under § 19–211(c) of the Health – General Article, as enacted by Section 1 of this Act.

(2) The study shall review the effect of the rates for a period of 2 full years after the rates become effective.

(3) On or before December 31, 2014, the Maryland Health Care Commission shall report the results of its study, in accordance with § 2–1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee.

(b) The Maryland Health Care Commission shall consider the data in the report required under subsection (a) of this section and other pertinent data in establishing review criteria and standards for issuing a certificate of need required to establish a freestanding medical facility in the State after July 1, 2015.

(c) A freestanding medical facility may not be established in the State without a certificate of need issued after July 1, 2015, by the Maryland Health Care Commission.

SECTION 5. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission shall set rates that apply to all payors, effective October 1, 2010, for hospital services, as defined in § 19–201 of the Health – General Article, as enacted by Section 1 of this Act, provided at a freestanding medical facility pilot project described in § 19–3A–07(b)(2) of the Health – General Article, as enacted by Section 1 of this Act, in a manner that does not result in a fiscal impact on the fiscal year 2011 State budget.

SECTION 6. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission shall set rates that apply to all payors, effective July 1, 2011, for hospital services, as defined in § 19–201 of the Health – General Article, as enacted by Section 1 of this Act, provided at:

(1) a freestanding medical facility licensed prior to July 1, 2007; and

(2) a freestanding medical facility pilot project described in § 19–3A–07(b)(1) of the Health – General Article, as enacted by Section 1 of this Act.

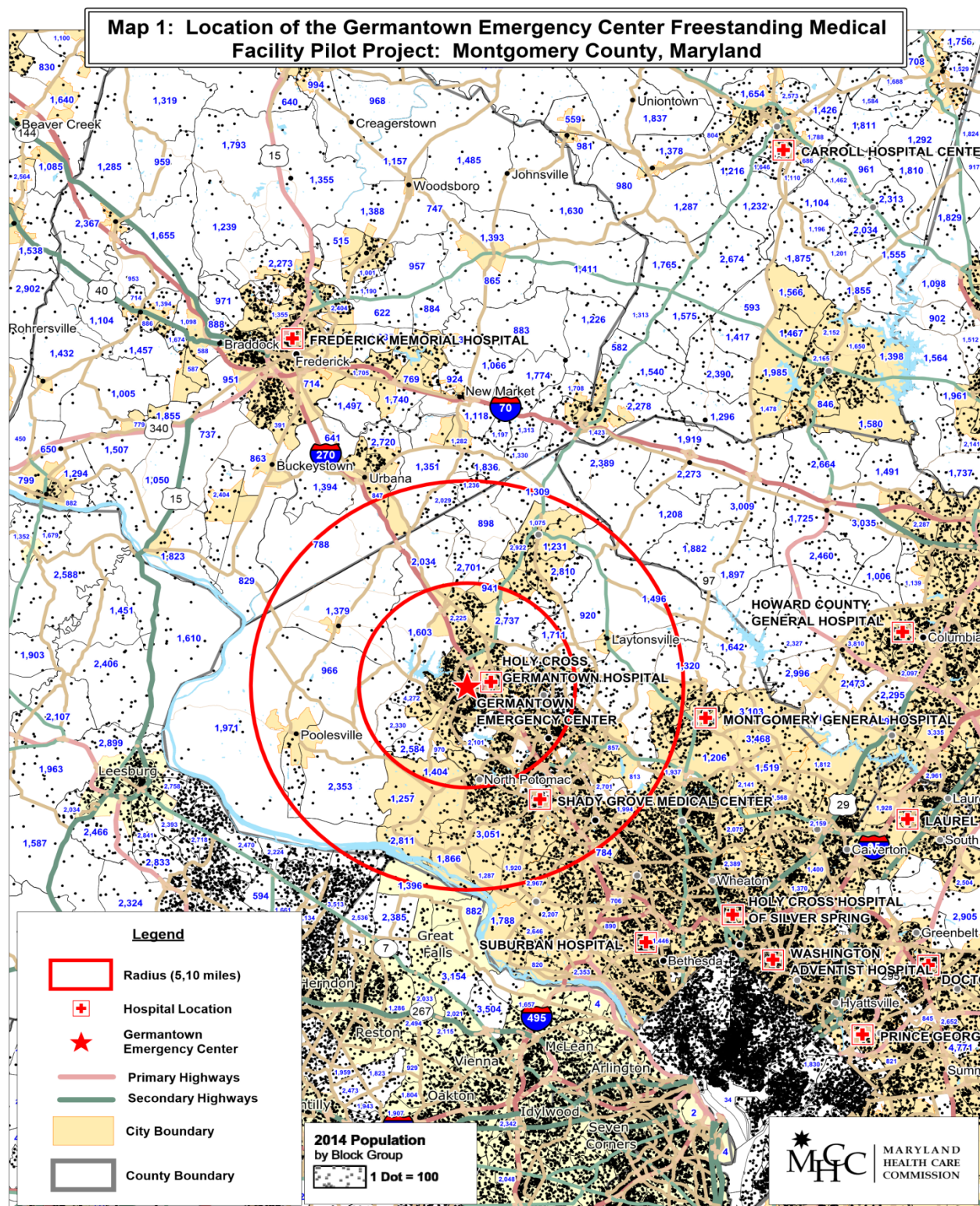
Appendix 4

Profiles of Maryland Freestanding Medical Facilities

Germantown Emergency Center

Germantown Emergency Center was established under the auspices of Adventist HealthCare Shady Grove Medical Center, known until recently as Shady Grove Adventist Hospital. SGMC is a member of Adventist HealthCare, Inc., a merged asset system that includes Washington Adventist Hospital as well as facilities providing specialty hospital and home health agency services. The Germantown Emergency Center is located on a four-acre site in Montgomery County at 19731 Germantown Road, Germantown, Maryland in a 17,000 square foot building adjacent to a physician office building.

The location of the Germantown Emergency Center in relation to Shady Grove Medical Center and other nearby acute care hospitals is shown in Map 1. Maryland's newest general hospital, Holy Cross Germantown Hospital, which opened in October 2014, is within two miles of Germantown Emergency Center. Germantown Emergency Center is located 9 miles from Shady Grove Medical Center and 17.5 miles from Montgomery General Hospital in Olney.



Source: Spatial Insight, Inc.

Within the five mile radius surrounding the Germantown Emergency Center, there are about 216,282 Montgomery County residents. The population increases to about 411,439 within a 10-mile radius of the facility. Map 2 shows patterns of population growth between 2000 and 2014 in the areas surrounding the Germantown Emergency Center.

Map 2: Percent Change in Population Surrounding the Germantown Emergency Center Freestanding Medical Facility Pilot Project: 2000-2014

Legend

- Radius (5, 10 miles)
- Hospital Location
- Germantown Emergency Center
- Primary Highways
- Secondary Highways
- County Boundary
- City Boundary

Population Change from 2000 to 2014 by Block Group

(Dark Blue)	20%+
(Medium Blue)	15% to 20%
(Light Blue)	10% to 15%
(Very Light Blue)	0% to 10%
(White)	Less than 0%

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An analysis of the age composition within the five-mile radius shows that a fairly high proportion of the population is young. While about 24 percent of Maryland's population is 18 years of age or younger, about 27 percent of the population living in the area immediately surrounding the Germantown Emergency Center (zip code areas 20874, 20875, & 20876) and within a five-mile radius are in this younger age group. A much smaller proportion of the population living around the Germantown Emergency Center is in the 65 years and older age group (9.0%), an age group projected to account for 14.0% of the State's total population in 2015. Persons aged 65 and older who are seen at an emergency department are much more likely to be admitted to a hospital than younger people, based on MHCC staff's review of emergency department visits at Maryland hospitals and freestanding medical facilities. In FY 2014, approximately 38 percent of emergency department visits resulted in admission to an acute care hospital for those age 65 and older compared to less than ten percent for those aged 40 or younger.

Patient Volumes and Referral for Admission to Inpatient Care

Shady Grove Medical Center experienced a substantial increase in demand for emergency department services between the years 2000 and 2006; for the period 2000 to 2014, the peak number of emergency department visits occurred in 2006. With the opening of Germantown Emergency Center in 2007, the volume of emergency department visits fell from 87,934 in FY 2006 to 77,881 in FY 2007 and then generally declined through FY 2014. This trend suggests that the opening of Germantown Emergency Center substantially reduced the volume of ED visits for SGMC.

Changes in the volume of emergency department visits at SGMC as compared to other hospital EDs in Montgomery County over the period FY 2009- FY 2014 also suggest that the reduction of ED visits at SGMC since 2006 is not just a reflection of a downward trend in ED visits for hospitals in Montgomery County or Maryland. In fiscal year 2009, SGMC, with about 75,000 emergency department visits, ranked 8th among all Maryland hospitals in the volume of emergency department visits. SGMC also had the second highest volume among Montgomery County hospitals. Holy Cross Hospital with almost 89,000 emergency department visits ranked 3rd in Maryland and had the highest volume in Montgomery County. In FY 2014, SGMC, with 71,531 emergency department visits, ranked 12th among all Maryland hospitals in the volume of emergency department visits. Emergency department visits at SGMC have declined approximately nine percent since FY 2009. The busiest emergency department in Montgomery County also experienced a decline in visits over the same five-year period, but only 4.5 percent.

The Germantown Emergency Center opened in August 2006 and began reporting data to the Commission for visits in October 2006. During its initial nine months of operation in FY 2007, there were a total of 17,898 visits to the Germantown Emergency Center. In the second and third years of operation, total visits increased to 30,784 and 33,353, respectively. The number of visits remained fairly consistent for the next three years and then grew to 38,018 in FY 2013. Visits to the Germantown Emergency Center declined a little over two percent from 2013 to 2014, dropping back to 37,247 visits. On average, there were 98 visits daily at the Germantown Emergency Center over the period of 2013-2014. The vast majority of patients visiting Germantown Emergency Center are discharged to home following treatment. As shown

in Table 1, only about five percent of all patients seen at Germantown Emergency Center were admitted to SGMC in FY 2013 and FY 2014.

Table 1
Number and Percent Distribution of Visits by Disposition:
Germantown Emergency Center, Fiscal Years 2012-2013

Fiscal Year	Patient Disposition		Total GEC Patients	% Distribution		Total GEC Patients
	Admitted to SGMC	Discharged from GEC		Admitted to SGMC	Discharged from GEC	
2012*	943	16,822	17,765	5.3%	94.7%	100.0%
2013	1,852	36,166	38,018	4.9%	95.1%	100.0%
2014	1,725	35,522	37,247	4.6%	95.4%	100.0%

Source: Email correspondence from SGMC staff to MHCC staff, December 5, 2014.

Note: The freestanding medical facilities data do not allow MHCC staff to identify which patients were admitted from GEC to SGMC.

*Includes only six months of data.

Service Area

The extended service area of the Germantown Emergency Center completely overlapped with the service area for Shady Grove Medical Center's emergency department in FY 2014, as shown in Table 2 and Map 3. The extended service area is defined as the zip code areas of residence for patients that, when ordered from the most frequent to the least frequent, are included in the top 85 percent of patient emergency department visits. The extended service area for the Shady Grove Medical Center emergency department includes 21 zip code areas, most of which are located in Montgomery County. The extended service area for the Germantown Emergency Center includes 14 zip code areas. Two Germantown zip code areas (zip code areas 20874 and 20876) accounted for 47.3 percent of all visits to the Germantown Emergency Center in FY 2014.

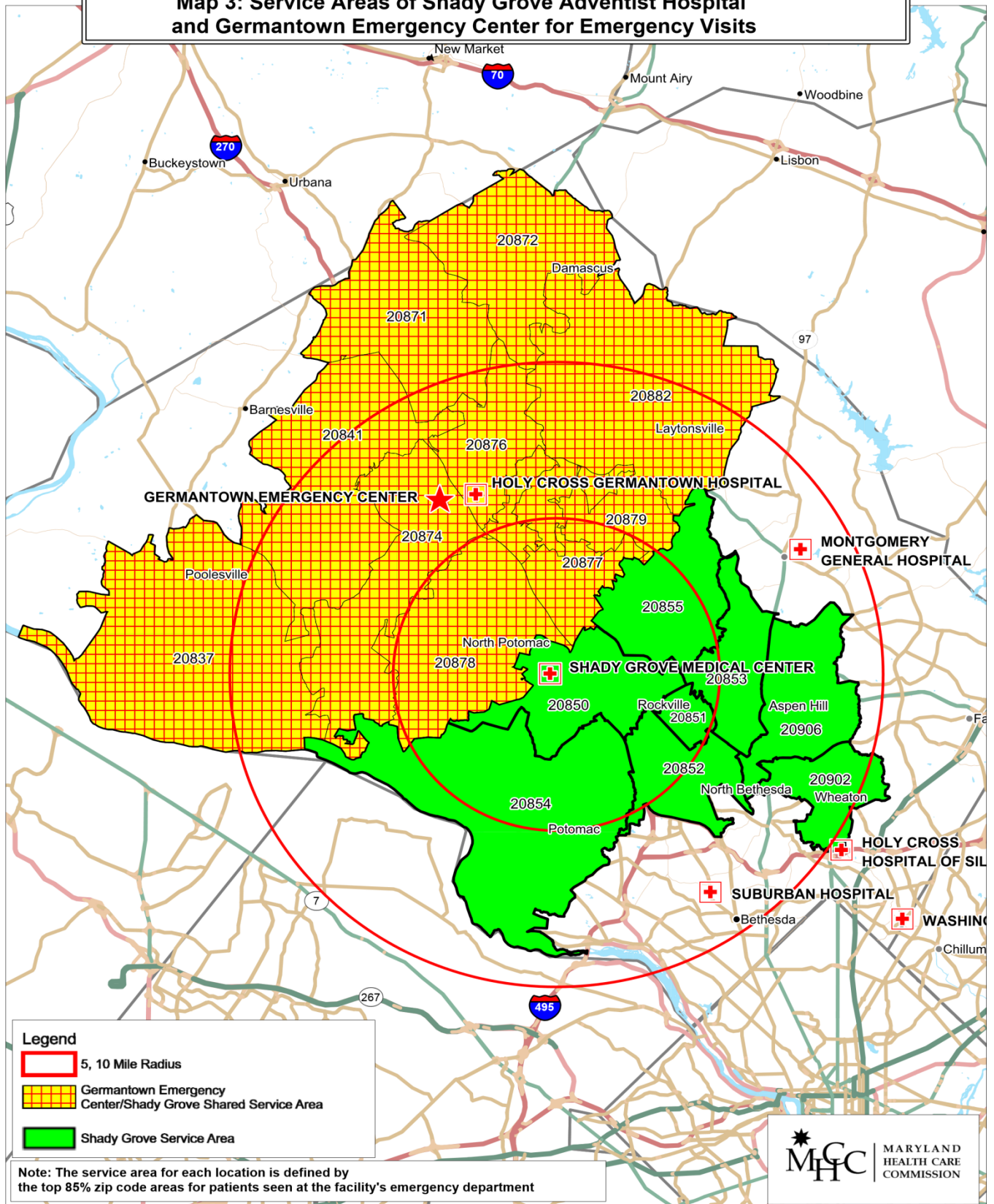
Table 2
Distribution of Visits by Zip Code of Patient Residence: Shady Grove Medical Center and the Germantown Emergency Center, Fiscal Year 2014

Zip Code Area	Description	Shady Grove Medical Center ED				Germantown Emergency Center			
		Visits	Percent of Total	Cumulative Percent	Rank	Visits	Percent of Total	Cumulative Percent	Rank
20878	Gaithersburg	8,564	12.3	12.3	1	2,135	6.2	6.2	4
20877	Gaithersburg	7,979	11.5	23.6	2	2,072	6.0	12.3	6
20850	Rockville	7,493	10.8	34.7	3				
20874	Germantown	6,646	9.6	44.2	4	11,678	34.1	46.3	1
20886	Montgomery Village	5,379	7.8	52.0	5	3,585	10.5	56.8	3
20879	Gaithersburg	4,333	6.3	58.2	6	2,079	6.1	62.9	5
20876	Germantown	2,993	4.3	62.5	7	4,523	13.2	76.1	2
20854	Potomac	2,509	3.6	66.2	8				
20855	Derwood	1,767	2.6	68.7	9				
20852	Rockville	1,520	2.2	70.9	10				
20851	Rockville	1,509	2.2	73.1	11				
20853	Rockville	1,383	2.0	75.1	12				
20906	Silver Spring	1,361	2.0	77.0	13				
20872	Damascus	1,245	1.8	78.8	14	1,617	4.7	80.8	8
20871	Clarksburg	1,013	1.5	80.3	15	1,983	5.8	86.6	7
20882	Gaithersburg	893	1.3	81.6	16				
20841	Boyd's	795	1.2	82.7	17				
20837	Poolesville	743	1.1	83.8	18				
20902	Silver Spring	548	0.8	84.6	19				
20904	Silver Spring	419	0.6	85.2	20				

Source: Email correspondence from SGMC staff to MHCC staff, December 5, 2014.

Note: Percentages are rounded to the nearest one-tenth percent.

Map 3: Service Areas of Shady Grove Adventist Hospital and Germantown Emergency Center for Emergency Visits



Source: Spatial Insights, Inc.

Visits per Treatment Space

On average, Maryland hospitals served 1,275 emergency department visits per treatment space in 2013. This is down from the visit per space ratio observed in 2008, a drop of 42 visits per treatment space. Utilization per treatment space at the Germantown Emergency Center (1,810 visits per treatment space in 2013) was well above the statewide average and also above the number of visits per treatment space at Shady Grove Medical Center (1,183) (Table 3). The number of emergency department visits per treatment space at SGMC has decreased by 215 since 2008.

There are a number of factors that impact planning for emergency department service capacity. The State Health Plan for Acute Care Hospital Services, COMAR 10.24.10, evaluates proposals for new construction or expansion of the emergency department based on parameters shown in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians (ACEP).¹ That document sets forth a series of eleven measures for determining the appropriate size for an emergency department together with low and high range parameters. These parameters include the percent of emergency department patients admitted to the hospital, the proportion of urgent/non-urgent patients, percent of patients 65 years of age and older, need for office or teaching spaces, specialty components of departments, and flight/trauma services support areas.

Although data are not available on all the ACEP parameters, several factors would suggest that the Germantown Emergency Center would be classified in the low range. For example, a comparatively low proportion of patients are admitted for inpatient care, and a low proportion of visits are for persons in older age groups. Based upon the ACEP guidelines, the Germantown Emergency Center would need between 20-25 treatment spaces to accommodate 30,000-40,000 annual visits (1,500-1,600 visits per treatment space). With 21 treatment spaces and about 38,000 visits in fiscal year 2013, the Germantown Emergency Center was operating within the ACEP guidelines, but with a relatively high number of visits per treatment space (1,810).

¹ COMAR 10.24.10.04B(14) .

Table 3
Total Visits, Treatment Spaces, and Visits per Treatment Space: Shady Grove Medical Center ED, Germantown Emergency Center, Other Montgomery County Hospitals, and Maryland Hospital Emergency Departments, Fiscal Year 2013

Facility	Total Visits	Treatment Spaces	Visits per Treatment Space
	2013	2013	2013
Shady Grove Medical Center	75,693	64	1,183
Germantown Emergency Center	38,018	21	1,810
Other Montgomery County Hospitals	225,672	171	1,320
All Maryland Hospital EDs	2,606,630	2,045	1,275

Sources: MHCC staff analysis of inpatient and outpatient data for SGMC and Montgomery County hospitals for FY 2013; HSCRC staff analysis of HSCRC financial database; the number of total visits for GEC is based on email correspondence from SGMC staff to MHCC staff, December 5, 2014; the number of treatment spaces is from the MHCC Supplemental Survey: Emergency Department Treatment Capacity as of June 1, 2013, *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2014*.

Patient Age

Among patients discharged following treatment, both the Germantown Emergency Center and the Shady Grove Medical Center emergency department serve a population that is younger, on average, than the statewide emergency department experience. Figure 1 and Table 4 compare the age profile of patients discharged following treatment using Shady Grove Medical Center and Germantown Emergency Center with other Montgomery County hospital emergency departments and with all hospital emergency departments in Maryland for fiscal years 2013 and 2014. During 2013, approximately 12.4 percent of the Germantown Emergency Center's emergency visits and 11.8 percent of Shady Grove Medical Center's emergency department visits were for patients zero to five years of age, compared to 5.7 percent of visits at Maryland hospital emergency departments.

Among patients not admitted to a hospital following an emergency department visit, those six to 15 years of age accounted for about 13.2 percent of the Germantown Emergency Center's visits and about 8.0 percent of Shady Grove Medical Center's emergency department visits, as compared to 5.7 percent for all Maryland hospitals. A smaller proportion of emergency visits at Germantown Emergency Center were for patients over 65 years of age as compared to the Shady Grove Medical Center emergency department, other Montgomery County hospital emergency departments, and all Maryland hospitals. Only five percent of the Germantown Emergency Center's visits were for patients over 65 years of age, compared to 14.6 percent of the emergency visits at Shady Grove Medical Center, 19.6 percent at other Montgomery County hospitals' emergency departments, and 21.4 percent at hospital emergency departments statewide.

Including data provided by Shady Grove Medical Center staff on the patient population served at Germantown Emergency Center who were transferred for admission to Shady Grove Medical Center in FY 2013 and FY 2014 only changes the age distribution slightly. The

percentage of patients ages 41-65 and age 65 or older each increased by 1.2 percentage points, while the percentage of patients in other age groups decreased slightly, less than one percentage point in each case.

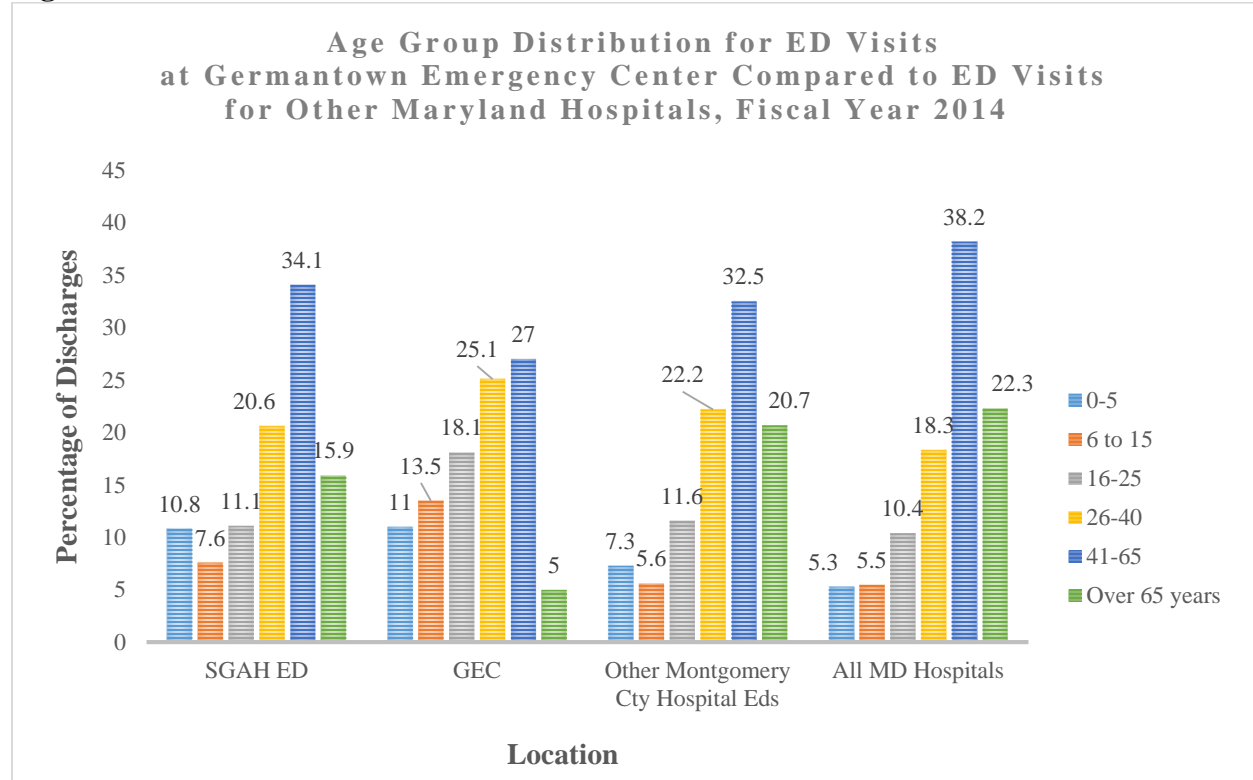
Table 4
Patients Discharged by Age Group: Shady Grove Medical Center ED,
Germantown Emergency Center, Other Montgomery County Hospital EDs,
and Maryland Hospital EDs, Fiscal Years 2013 and 2014

Year and Age Group (in years)	Discharged Patients				% Distribution by Age Group			
	SGMC ED	GEC	Other Mont. Co. Hosp. EDs	All Maryland Hospital EDs	SGMC ED	GEC	Other Mont. Co. Hosp. EDs	All Maryland Hosp. EDs
FY 2013								
0-5	11,854	4,363	24,167	318,998	11.8	12.4	8.1	5.7
6-15	7,993	4,657	17,196	318,750	8.0	13.2	5.8	5.7
16-25	11,254	6,301	35,056	607,764	11.2	17.9	11.8	10.8
26-40	20,631	8,826	64,707	1,028,147	20.5	25.0	21.8	18.3
41-65	34,117	9,438	97,915	2,147,435	33.9	26.8	33.0	38.2
Over 65	14,724	1,665	58,099	1,204,339	14.6	4.7	19.6	21.4
Total	100,573	35,250	297,140	5,625,433	100%	100%	100%	100%
FY 2014								
0-5	10,392	3,787	20,785	294,996	10.8	11.4	7.3	5.3
6-15	7,292	4,621	16,003	306,867	7.6	13.5	5.6	5.5
16-25	10,700	6,211	32,880	579,837	11.1	18.1	11.6	10.4
26-40	19,870	8,599	63,155	1,023,005	20.6	25.1	22.2	18.3
41-65	32,834	9,360	92,385	2,131,897	34.1	27.3	32.5	38.2
Over 65	15,322	1,713	58,735	1,242,384	15.9	5.0	20.7	22.3
Total	96,410	34,291	283,943	5,578,986	100%	100%	100%	100%

Source: MHCC staff analysis of HSCRC outpatient data and freestanding medical facilities data.

Notes: Hospitals included in the category "Other Montgomery Hospitals" are Holy Cross-Silver Spring, Montgomery General, Suburban, and Washington Adventist. In addition, only emergency department visits that did not result in admission to a hospital are included. Percentages are rounded to the nearest one-tenth percent.

Figure 1

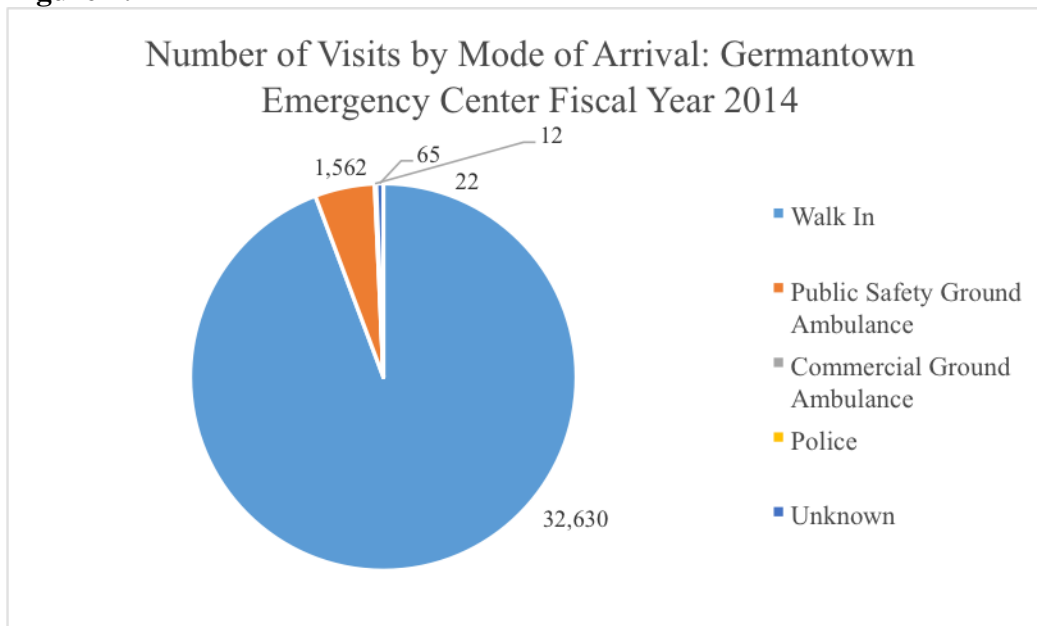


Source: MHCC staff analysis of HSCRC outpatient data and freestanding medical facilities data.

Patient Mode of Arrival and Registration Times

The majority of patients (95.2%) arriving at the Germantown Emergency Center in 2014 were walk-in patients (32,630 total). The percentage of walk-in patients has declined slightly over the last several years. The percentage of walk-in patients in FY 2010 and FY 2011 was 97.3 percent, slightly higher than in FY 2012, FY 2013, and FY 2014. Approximately five percent of the patients arrived at the Center via public safety ground ambulance (1,562). The percentage arriving by ambulance has ranged from 2.5 percent and five percent between FY 2008 and FY 2014, without a clear upward or downward trend. The mode of arrival at the Germantown Emergency Center for FY 2014 is shown in Figure 2. Analysis of discharged visits from the Germantown Emergency Center by registration time shows that the percentage of discharges between 8:01am and 4:00pm declined from approximately 31 percent in FY 2011 to about 22 percent in FY 2014. Patients seen at Germantown Emergency Center most frequently registered between 4:01pm and 12:00am (57%), and the proportion of patients registering during those hours has remained consistent between FY 2010 and FY 2014. For this time period, the percentage of patients registering overnight, between 12:01am and 8:00am, increased from approximately 12 percent to 24 percent, as shown in Table 5. Comparative information for Shady Grove Medical Center is not available through the discharge abstract or the outpatient data sets.

Figure 2:



Source: MHCC staff analysis of freestanding medical facilities data.

Table 5
Discharged Visits by Registration Time and Arrival Mode: Germantown Emergency Center, Fiscal Years 2013 and 2014

Mode of Arrival and Fiscal Year	Number of Visits by Registration Time			Total	Percent Visits by Registration Time			Total
	Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight		Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight	
Fiscal Year 2011								
Walk-in	3,818	10,051	18,512	32,381	11.5	30.2	55.6	
Public Safety	137	226	514	877	0.4	0.7	1.5	
Ambulance								
Comm. Ambulance	4	0	5	9	< 0.1	0	< 0.1	
Police	6	13	15	34	< 0.1	< 0.1	0.1	
Unknown	0	1	2	3	0		< 0.1	
Total	3,947	10,291	19,048	33,304	11.9	30.9	57.2	100%
Fiscal Year 2012								
Walk-in	5,738	8,740	18,285	32,763	16.9	25.8	54.0	
Public Safety	164	200	487	851	0.5	0.6	1.4	
Ambulance								
Comm. Ambulance	52	46	112	210	0.2	0.1	0.3	
Police	6	16	10	32	<0.1	0.1	< 0.1	
Unknown	4	4	5	13	<0.1	< 0.1	< 0.1	
Total	5,964	9,006	18899	33,869	17.6	26.6	55.8	100%
Fiscal Year 2013								
Walk-in	7,821	7,027	18,381	33,229	22.2	19.9	52.1	
Public Safety	475	338	953	1,766	1.4	1.0	2.7	
Ambulance						< 0.1		
Comm. Ambulance	12	3	16	31	< 0.1	<0.1	0.1	
Police	5	1	10	16	< 0.1	0.2	< 0.1	
Unknown	31	64	113	208	0.1		0.3	
Total	8,344	7,433	19,473	35,227	23.7	21.1	55.2	100%
Fiscal Year 2014								
Walk-in	6,679	7,292	18,659	32,630	19.5	21.3	54.4	
Public Safety	396	321	845	1,562	1.2	0.9	2.5	
Ambulance								
Comm. Ambulance	4	4	4	12	< 0.1	< 0.1	< 0.1	
Police	4	3	15	22	< 0.1	< 0.1	< 0.1	
Unknown	34	8	23	65	0.1	< 0.1	0.1	
Total	7,117	7,628	19,546	34,291	20.8	22.2	57.0	100%

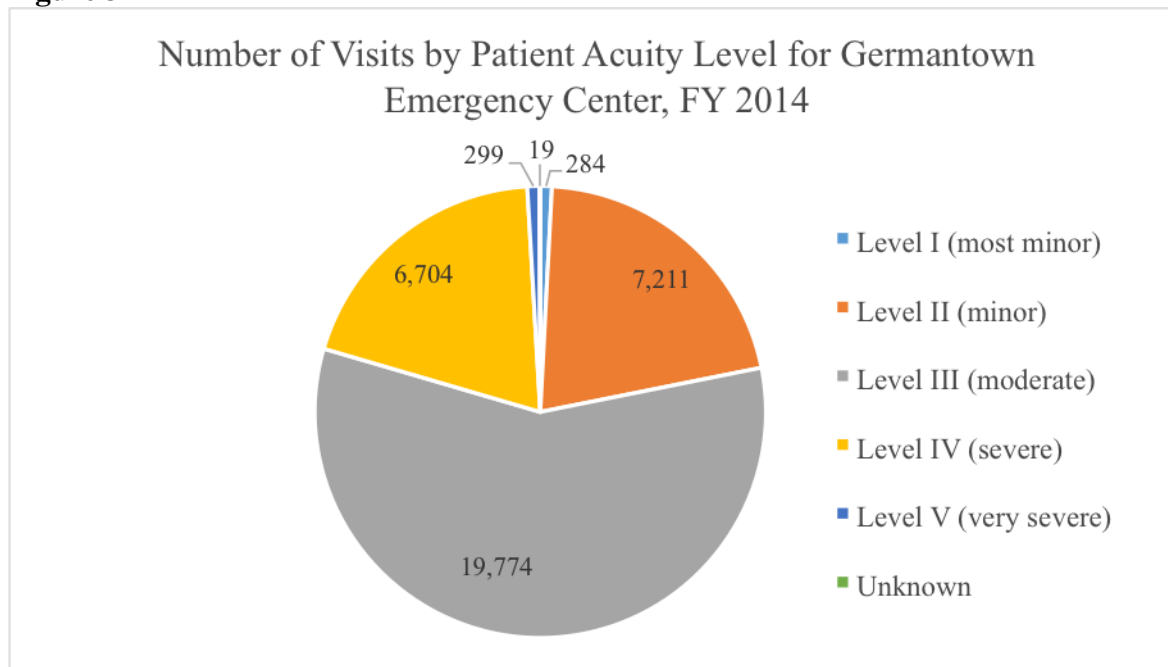
Source: MHCC staff analysis of freestanding medical facilities data.

Note: Percentages are rounded to the nearest one-tenth percent; values greater than zero and less than one-tenth percent are indicated rather than rounded to zero.

Patient Acuity

As shown in Table 6, among the patient visits for Germantown Emergency Center in FY 2014 that did not result in admission to an acute care hospital, less than one percent of the visits were classified as non-urgent with minor problems (Level I). Approximately 21 percent were classified as Level II acuity and almost 58 percent were Level III, or moderate acuity level. Figure 3 shows the proportion of visits by acuity level, as well as the number of visits in each category for FY 2014.

Figure 3



Source: MHCC staff analysis of Freestanding Medical Facility Data FY 2014

Note: Only visits for patients not transferred and admitted to an acute care hospital are included.

The percentage of low acuity patients, both Level I and II, has decreased since 2011. In 2012, there were dramatic changes for all acuity levels, as shown in Table 6. Prior to 2012, a majority of emergency visits were coded as Level I or II, and less than ten percent of cases were coded as Level IV or V. In 2012, 2013, and 2014, Level IV cases increased to approximately 20 % of visits. The percentage of Level V visits approximately tripled for the same period, but still accounted for only approximately one percent of visits.

Table 6
Percentage of Visits by Acuity Level:
Germantown Emergency Center, Fiscal Years 2008- 2014

Acuity Level	2008	2009	2010	2011	2012	2013	2014
Level I	5.5	1.3	4.4	4.3	1.6	1.3	0.8
Level II	61.9	61.8	48.8	49.1	18.9	20	21
Level III	30.9	32.2	39.6	38.9	57.6	57.8	57.7
Level IV	1.7	4.4	6.8	7.2	20.9	20.1	19.6
Level V	0	0.2	0.3	0.3	1	0.8	0.9
Unknown	0.1	0.2	0.2	0.2	0.1	0.1	0.1
Total	100	100	100	100	100	100	100

Source: MHCC staff analysis of freestanding medical facilities data, FY 2010- FY 2014.

Note: For this analysis, the fiscal year is defined as beginning July 1st and ending June 30th.

As compared to the Shady Grove Medical Center ED, other hospital EDs in Montgomery County, and all Maryland hospital EDs, Germantown Emergency Center serves a lower acuity

patient population, even when visits not resulting in hospital admission are excluded. While less than one percent of visits for Germantown Emergency Center were the highest acuity visits (Level V or critical) during the period FY 2011- FY 2014, as shown in Table 6, approximately eight percent of visits at Germantown Emergency Center fell in this category, as shown in Table 7. Statewide, the average proportion of visits in this category was even higher, ranging from approximately ten to 13% between FY 2011 and FY 2014, as shown in Table 8.

Similar to Germantown Emergency Center, Shady Grove Medical Center had an increase in the proportion of higher acuity emergency visits, but the shift occurred earlier, between 2009 and 2010. As shown in Table 7, the proportion of Level II visits, low acuity, decreased from 40.9 % in 2009 to 12.8 % in 2010, while the proportion of Level IV visits, high acuity, increased from 8.1% in 2009 to 36.2 percent in 2010. In each case, the shift was maintained in the subsequent three or four years.

Table 7
Percentage of ED Visits by
Acuity Level: Shady Grove Medical Center, Fiscal Years 2008-2014

Acuity Level	2008	2009	2010	2011	2012	2013	2014
Level I	5.2	2.5	1.0	1.1	1.5	1.8	1.2
Level II	46.1	40.9	12.8	10.4	9.8	9.7	10.0
Level III	34.9	40.3	39.8	44.2	43.4	42.0	41.0
Level IV	7.6	8.1	36.2	35.2	35.6	33.7	35.0
Level V	2.5	3.8	7.6	7.5	7.5	8.0	8.1
Critical	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Unknown	3.7	4.4	2.5	1.6	2.2	4.7	4.7
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: MHCC staff analysis of outpatient data for SGMCC.

Note: Visits resulting in admission to the hospital are not included in this analysis.

Other hospitals in Montgomery County appear to have experienced a less dramatic shift to higher acuity emergency department visits beginning in 2012. The proportion of Level II visits, low acuity, decreased from 20.6% in 2011 to 12.3% in 2012. In addition, the proportion of Level IV, high acuity visits, increased from 26.7% in 2011 to 34.3 percent in 2012. On a statewide basis, the shift to higher acuity emergency visits also appears less dramatic. The decline in the proportion of Level II visits appears to have been a steady gradual decline between 2011 and 2014. Concurrently, there was a steadily increasing proportion of Level IV and Level V for this period, as shown in Table 8.

Table 8
Percentage of ED Visits by
Acuity Level: Maryland Hospitals, Fiscal Years 2008-2014

Acuity Level	2008	2009	2010	2011	2012	2013	2014
Level I	6.7	5.8	4.8	4.7	4.8	4.9	4.5
Level II	25.9	23.3	20.5	19.4	17.6	15.5	12.9
Level III	37.9	38.3	37.6	36.6	36.6	36.9	36.6
Level IV	21.1	24.4	27.3	28.1	29.3	30.2	31.6
Level V	6.3	7.1	8.6	9.8	10.4	11.0	12.9
Critical	0.0	0.0	0.0	0.1	0.1	0.2	0.2
Unknown	2.1	1.2	1.2	1.3	1.3	1.4	1.3

Source: MHCC staff analysis of outpatient data for Maryland hospitals.

Notes: Visits resulting in admission to the hospital are not included in this analysis.

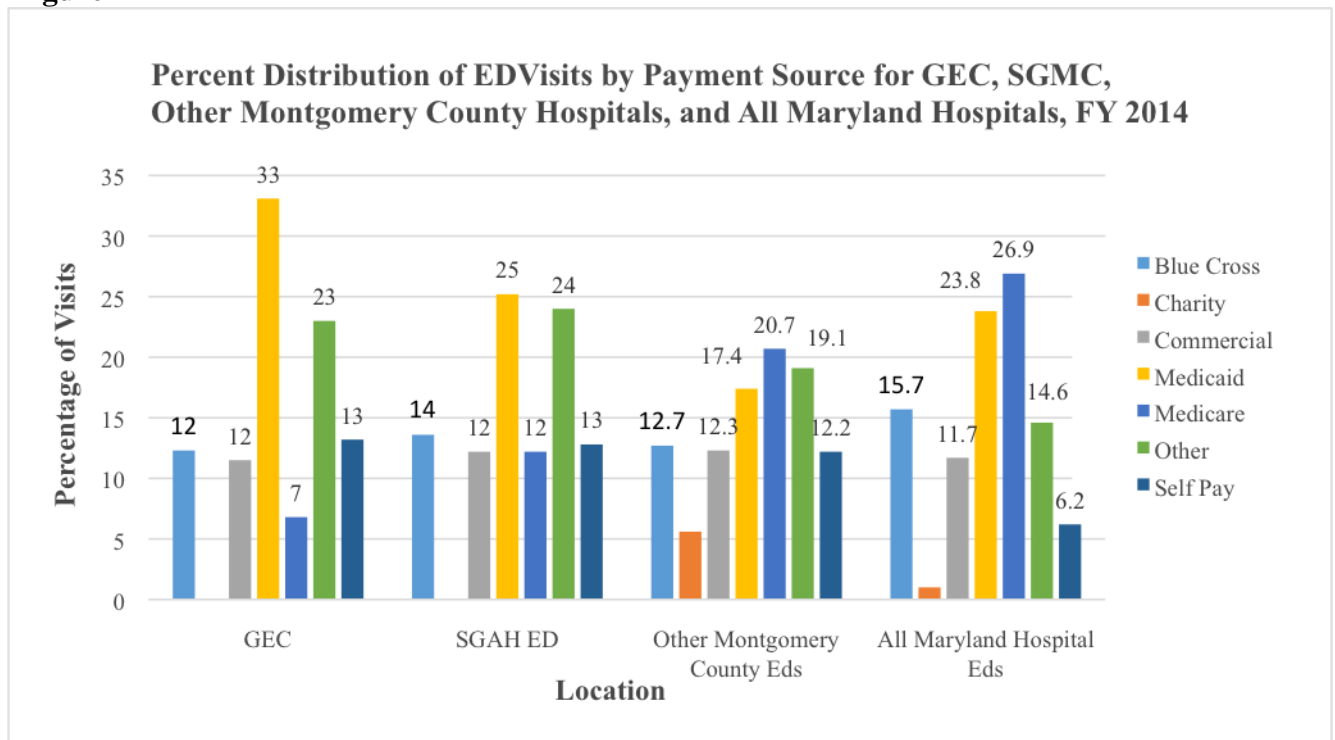
Payment Sources

Both Figure 4 and Table 9 provide comparative information on the payer source for emergency visits at Germantown Emergency Center, SGMHC, other Montgomery County hospitals, and all Maryland acute care general hospitals collectively. For FY 2014, among emergency department visits for Maryland hospitals that did not result in admission to an acute care hospital, the most frequent payment source is Medicare (26.9%), followed by Medicaid (23.8%). However, at the Germantown Emergency Center, Medicaid beneficiaries accounted for a higher proportion of emergency visits in FY 2014 (32.7%), and the percentage of Medicare visits was much lower (6.8%). For SGMHC, its proportion of emergency department visits with Medicare as the payment source (12.2%) is much lower than the statewide proportion (26.9%). However, SGMHC's proportion of emergency department visits with Medicaid as the payment source (25.2%) is similar to the statewide average (26.9%).

Since FY 2008, the percentage of visits from beneficiaries of either Medicare or Medicaid has increased at the Germantown Emergency Center. In FY 2008, 15.8% of visits had Medicaid as the payer source, compared to 32.7% for FY 2014. The percentage of visits with Medicare as the payment source increased less dramatically for this time period, from 5.1% in FY 2008 to 6.8% in FY 2014.

As shown in Figure 4 and Table 9, commercially insured patients accounted for 11.7% of emergency department visits in the state in 2014, which is similar to the percentage for the Germantown Emergency Center (11.5%) and SGMHC (12.2%). The percentage of individuals who are classified as "self-pay" at the Germantown Emergency Center (14%) and SGMHC ED (12.8%) is approximately double that of self-pay in all of Maryland EDs (6.2%).

Figure 4



Source: MHCC staff analysis of outpatient data and freestanding medical facilities data.

Note: Only ED visits not followed by admission to an acute care hospital are included.

Table 9
Discharged Visits by Payment Source: Shady Grove Medical Center,
Germantown Emergency Center, Other Montgomery County Hospital EDs,
and All Maryland Hospital EDs: Fiscal Years 2013-2014

Payment Source	Discharged Visits by Payment Source				Percent Distribution by Payment Source			
	SGMC ED	GEC	Other Montgomery County Hospital EDs	All MD Hospital EDs	SGMC ED	GEC	Other Montgomery County Hospital EDs	All MD Hospital EDs
Fiscal Year 2013								
Blue Cross	8,801	3,997	37,695	914,533	14.1	11.3	12.7	16.2
Charity	273	103	17,752	72,069	0.4	0.3	6.0	1.3
Commercial	6,921	3,986	35,440	673,010	11.1	11.3	11.9	12.0
Medicaid	14,786	10,363	51,085	1,241,314	23.7	29.4	17.2	22.1
Medicare	6,676	2,298	58,863	1,461,294	10.7	6.5	19.8	26.0
Other	15,655	8,694	55,910	820,395	25.0	24.7	18.8	14.6
Self- Pay	9,354	5,785	39,908	432,402	15.0	16.4	13.4	
Unknown	33	7	487	10,416		< 0.1	< 0.1	
Total	62,499	35,233	297,140	5,625,433	100%	100%	100%	100%
Fiscal Year 2014								
Blue Cross	8,300	4,227	35,964	878,643	13.6	12.3	12.7	15.7
Charity	36	15	16,000	52,220		< 0.1	5.6	1.0
Commercial	7,451	3,942	34,802	655,028	12.2	11.5	12.3	11.7
Medicaid	15,361	11,347	49,298	1,326,557	25.2	33.1	17.4	23.8
Medicare	7,464	2,335	58,736	1,503,393	12.2	6.8	20.7	26.9
Other	14,670	7,889	54,371	814,621	24.0	23.0	19.1	14.6
Self- Pay	7,789	4,514	34,741	347,840	12.8	13.2	12.2	6.2
Unknown			29	672				
Total	61,071	34,269	283,941	5,578,974	100%	100%	100%	100%

Source: MHCC staff analysis of freestanding medical facility data and outpatient data for Maryland hospitals.

Financial Performance

The financial performance of Germantown Emergency Center is covered in detail in the report. Please refer to pages 14-16 of the report.

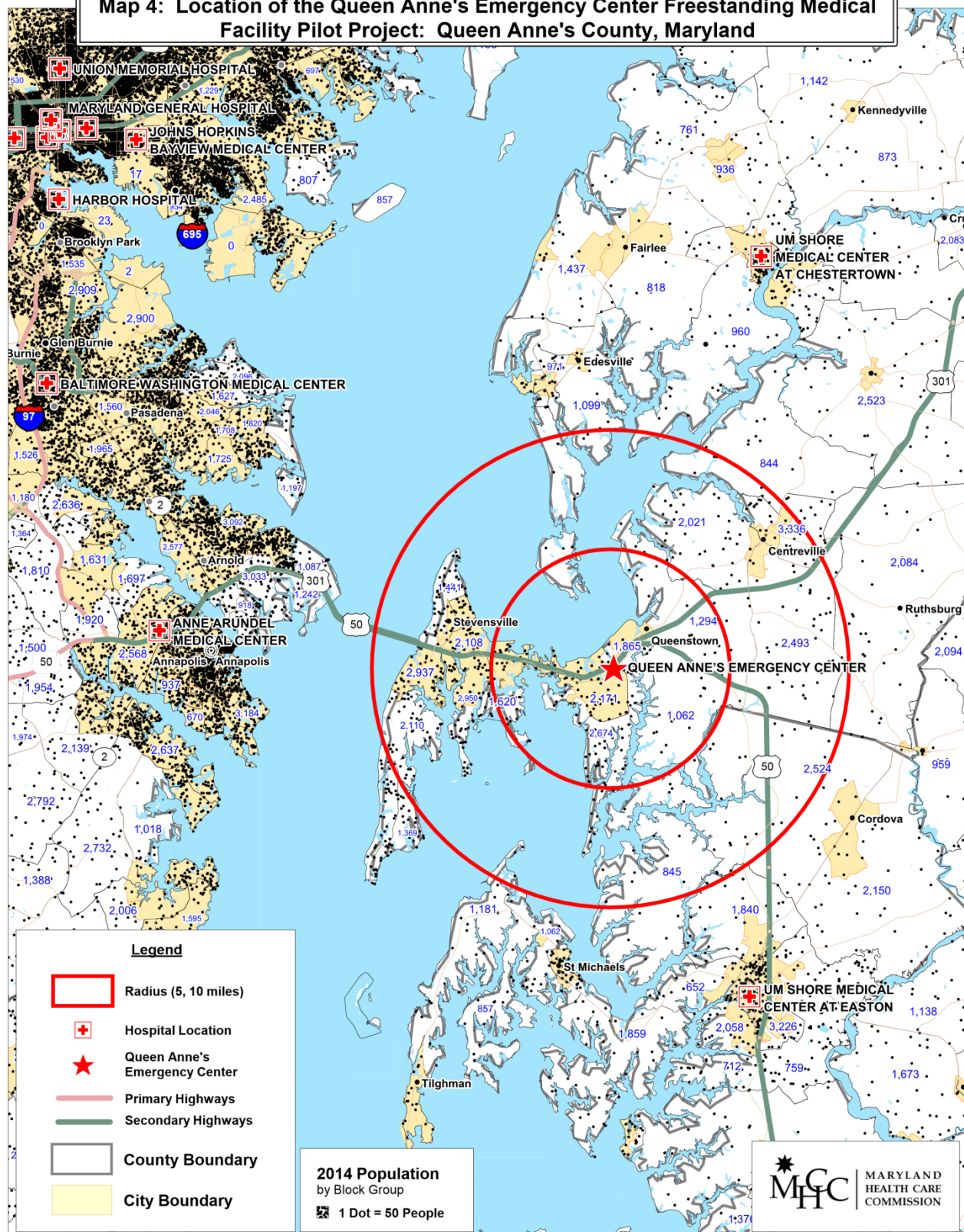
Queen Anne's Emergency Center

The Queen Anne's Emergency Center was established under the auspices of the University of Maryland Medical System; a merged asset system with eleven general acute care hospitals, including the three-hospital Shore Health System. The acute care hospitals that are part of this system include UM Shore Medical Center at Easton (Talbot County), UM Shore Medical Center at Dorchester (Dorchester County), and UM Shore Medical Center at Chestertown (Kent County). The Queen Anne's Emergency Center is affiliated with UM Shore Medical Center at Easton, which is located in Talbot County. The Queen Anne's Emergency Center is approximately 21 miles from the UM Shore Medical Center at Easton and 24 miles from Anne Arundel Medical Center in Anne Arundel County, the two closest general hospitals to the FMF. Map 4 shows the location of the Queen Anne's Emergency Center in relation to the UM Shore Medical Center and the Anne Arundel Medical Center

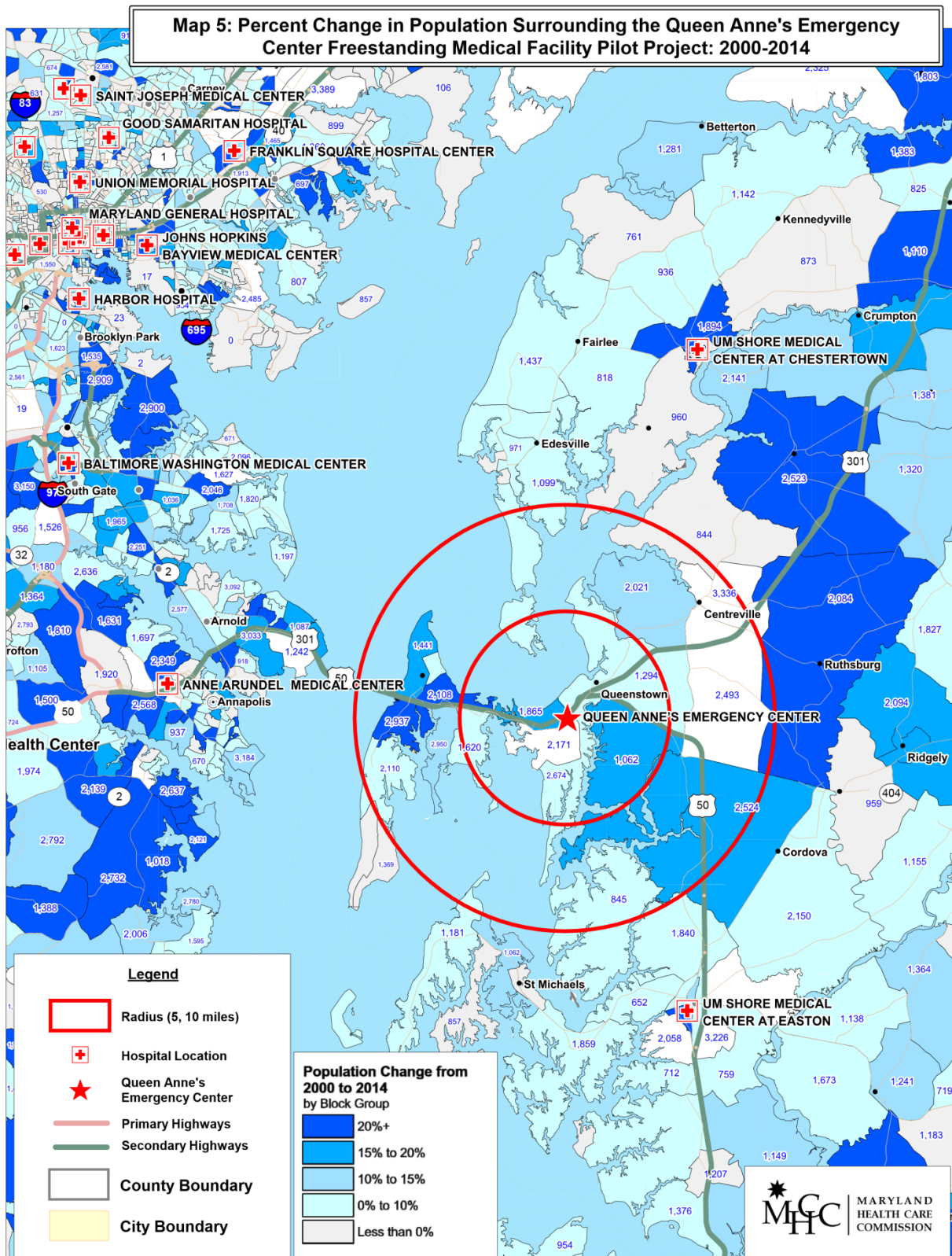
Within the five mile radius surrounding the Queen Anne's site, the population is estimated to be 9,057 residents. The population increases to 32,933 within a 10-mile radius of the facility. Map 4 shows patterns of population growth surrounding the site of the Queen Anne's Emergency Center. The population immediately surrounding the Queen Anne's pilot project site is older than the statewide average for Maryland residents. In 2014, approximately 20 percent of the Maryland residents living within a 5-mile radius of the Queen Anne's site were 65 years of age and older, as compared to 14 percent projected for the State in 2015.² Map 5 shows changes in population surrounding the Queen Anne's Emergency Center between 2000 and 2014.

² Maryland Department of Planning, July, 2014 population projections

Map 4: Location of the Queen Anne's Emergency Center Freestanding Medical Facility Pilot Project: Queen Anne's County, Maryland



Source: Spatial Insights, Inc.



Patient Volumes and Admission for Inpatient Care

The Queen Anne's Emergency Center, the second of two pilot freestanding medical facilities, opened in October of 2010. Table 10 shows the volume of visits and the percentage of visits that resulted in admission to an acute care hospital for FY 2011 to FY 2014. For FY 2011, there were a total of 9,461 visits to the Queen Anne's Emergency Center. In the second year of operation, the number of visits increased by over 40% to 13,589 in FY 2012. The number of visits in the third and fourth years of operation increased slightly, about 3% each year. In FY 2014, there were a total of 14,435 visits at Queen Anne's Emergency Center; an average of 39.5 visits per day.

As shown in Table 17, the majority of patient visits at Queen Anne's Emergency Center do not result in referral and admission to a general acute care hospital. For FY 2011 to FY 2014, approximately three percent of patients were admitted.

Table 10
Number and Percent Distribution of Visits by Disposition:
Queen Anne's Emergency Center, Fiscal Years 2012-2013

Fiscal Year	Patient Disposition		Total QAEC Patients	Percent Distribution		Total QAEC Patients
	Admitted to Hospital	Not Admitted to Hospital		Admitted to Hospital	Not Admitted to Hospital	
2011	323	9,138	9,461	3.4%	96.6%	100.0%
2012	401	13,533	13,589	3.0%	97.0%	100.0%
2013	454	14,059	14,059	3.2%	96.8%	100.0%
2014	424	14,011	14,435	2.9%	97.1%	100.0%

Source: MHCC staff analysis of freestanding medical facilities data.

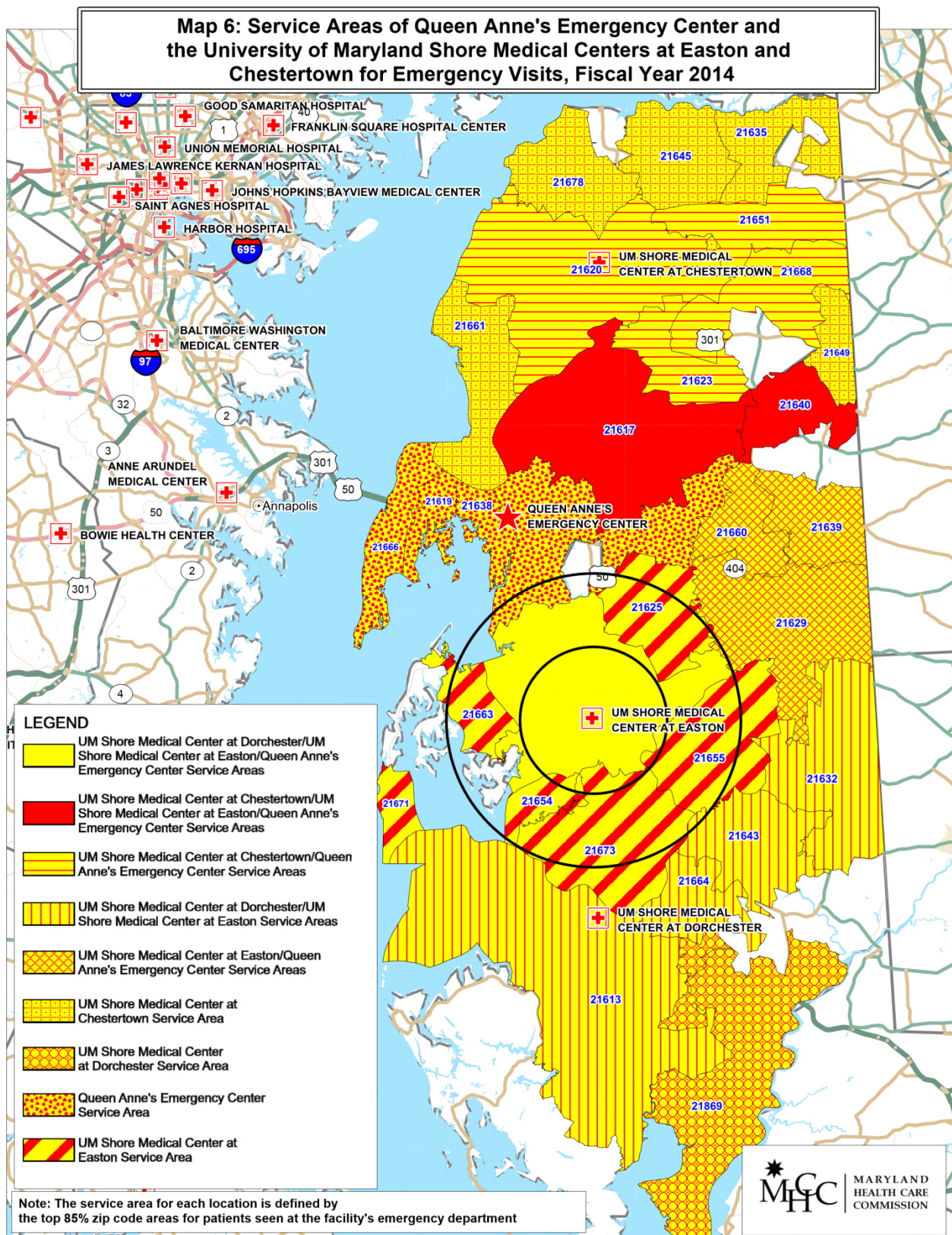
Service Area

The extended service area of the Queen Anne's Emergency Center partially overlaps with the extended service area for UM Shore Medical Center at Easton, its parent hospital and the nearest general hospital, in fiscal year 2014, as shown in Table 11. The extended service area is defined as the zip code areas of residence for patients that when ordered from the most frequent to the least frequent are included in the top 85% of patient emergency department visits. For UM Shore Medical Center at Easton, its service area for emergency department visits includes 16 zip code areas, and the extended service area for the Queen Anne's Emergency Center includes 15 zip code areas. The overlapping extended service area accounts for approximately 29 percent of the total emergency visits to Queen Anne's Emergency Center, as shown in Table 11 and Map 6. However, the overlapping zip code areas account for about half of the total emergency visits for UM Shore Medical Center at Easton. In addition, the extended service area for UM Shore Medical Center at Chestertown overlaps extensively with Queen Anne's emergency Center. Approximately 61% of visits from the extended service area of UM Shore Medical Center at Chestertown are from zip code areas that are part of the extended service area for Queen Anne's Emergency Center. There is no overlap with the extended service area for Anne Arundel Medical Center and very little overlap with UM Shore Medical Center at Dorchester (less than 2%).

Table 11
Distribution of Visits by Zip Code of Patient Residence: UM Shore Medical Center at Easton and the Queen Anne's Emergency Center, Fiscal Year 2014

Zip Code Area	UM Shore Medical Center at Easton ED				Queen Anne's Emergency Center			
	Visits	Percent of total	Cumulative Percent	Rank	Visits	Percent of total	Cumulative Percent	Rank
21601	10,647	29.7	29.7	1	262	1.8	1.8	11
21629	3,340	9.3	39.0	2	559	3.9	5.7	6
21632	2,547	7.1	46.1	3				
21655	2,246	6.3	52.4	4				
21613	2,041	5.7	58.1	5				
21643	1,655	4.6	62.7	6				
21639	1,444	4.0	66.7	7	409	2.8	8.5	8
21660	1,319	3.7	70.4	8	421	2.9	11.5	7
21663	1,259	3.5	73.9	9				
21673	1,233	3.4	77.4	10				
21625	834	2.3	79.7	11				
21617	706	2.0	81.7	12	2,361	16.4	27.9	2
21654	324	0.9	82.6	13				
21671	324	0.9	83.5	14				
21640	281	0.8	84.3	15	142	1.0	28.8	14
21631	271	0.8	85.0	16				
21666					2,392	16.6	45.5	1
21638					1,897	13.2	58.6	3
21619					1,586	11.0	69.7	4
21658					1,163	8.1	77.7	5
21623					314	2.2	79.9	9
21620					292	2.0	81.9	10
21657					231	1.6	83.5	12
21651					147	1.0	84.6	13
21668					136	0.9	85.5	15

Source: MHCC staff analysis of freestanding medical facilities data for Queen Anne's Emergency Center; MHCC staff analysis of inpatient discharge data and outpatient data for UM Shore Medical Center at Easton.
Note: Percentages are rounded to the nearest one-tenth percent.



Source: Spatial Insights, Inc.

Visits per Treatment Space

Utilization per treatment space at the Queen Anne's Emergency Center (1,003 visits per treatment space in 2013) fell below both the statewide average for all hospital EDs (1,275) and the visits per treatment space at UM Shore Medical Center at Easton ED (1,122). However, as shown in Table 12, the treatment capacity has been increasing since the facility opened in 2010.

Table 12
Total Visits, Treatment Spaces, and Visits per Treatment Space: UM Shore Medical Center at Easton ED, Queen Anne's Emergency Center, and Maryland Hospital Emergency Departments, Fiscal Years 2012 and 2013

Facility	Total Visits		Treatment Spaces		Visits Per Treatment Space	
	2012	2013	2012	2013	2012	2013
UM Shore Medical Center at Easton ED	38,003	38,147	34	34	1,118	1,122
Queen Anne's Emergency Center	13,554	14,041	14	14	968	1,003
All Maryland Hospital EDs	2,605,182	2,593,550	2,003	2,045	1,301	1,268

Sources: MHCC staff analysis of inpatient and outpatient data for UM Shore Medical Center at Easton for FY 2012-13; HSCRC staff analysis of HSCRC financial database; MHCC staff analysis of freestanding medical facilities data for Queen Anne's Emergency Center; the number of treatment spaces is from the MHCC Supplemental Survey: Emergency Department Treatment Capacity as of June 1, 2013, *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2014*.

Patient Age

Queen Anne's Emergency Center serves a higher proportion of persons age 25 or younger, as compared to the statewide average for ED visits at Maryland hospitals. As shown in Table 13 and Figure 5, in FY 2014 about 8.4% of visits were for patients aged five or younger compared to 5.3% for all Maryland hospitals. Visits for patients aged six to 15 years accounted for about 12% of visits at Queen Anne's Emergency Center in FY 2014, but only 5.5% for all Maryland hospitals. Patients aged 16 to 25 accounted for 16.1% of visits at Queen Anne's Emergency Center, but only 10.4% of visits for all Maryland hospital EDs.

As shown in Table 13, the emergency department at UM Shore Medical Center at Easton serves a population that is older, as compared to Queen Anne's Emergency Center. The population served by UM Shore Medical Center at Easton is also older compared to the population evaluated in Maryland hospital EDs. Approximately 29% of the UM Shore Medical Center at Easton emergency visits were for patients age 65 and older in 2014 compared to approximately 14% of the patients at the Queen Anne's Emergency Center and 22.3% statewide for hospital EDs for FY 2014. In FY 2013, the age distribution pattern was similar to FY 2014 for each of the locations shown in Table 13.

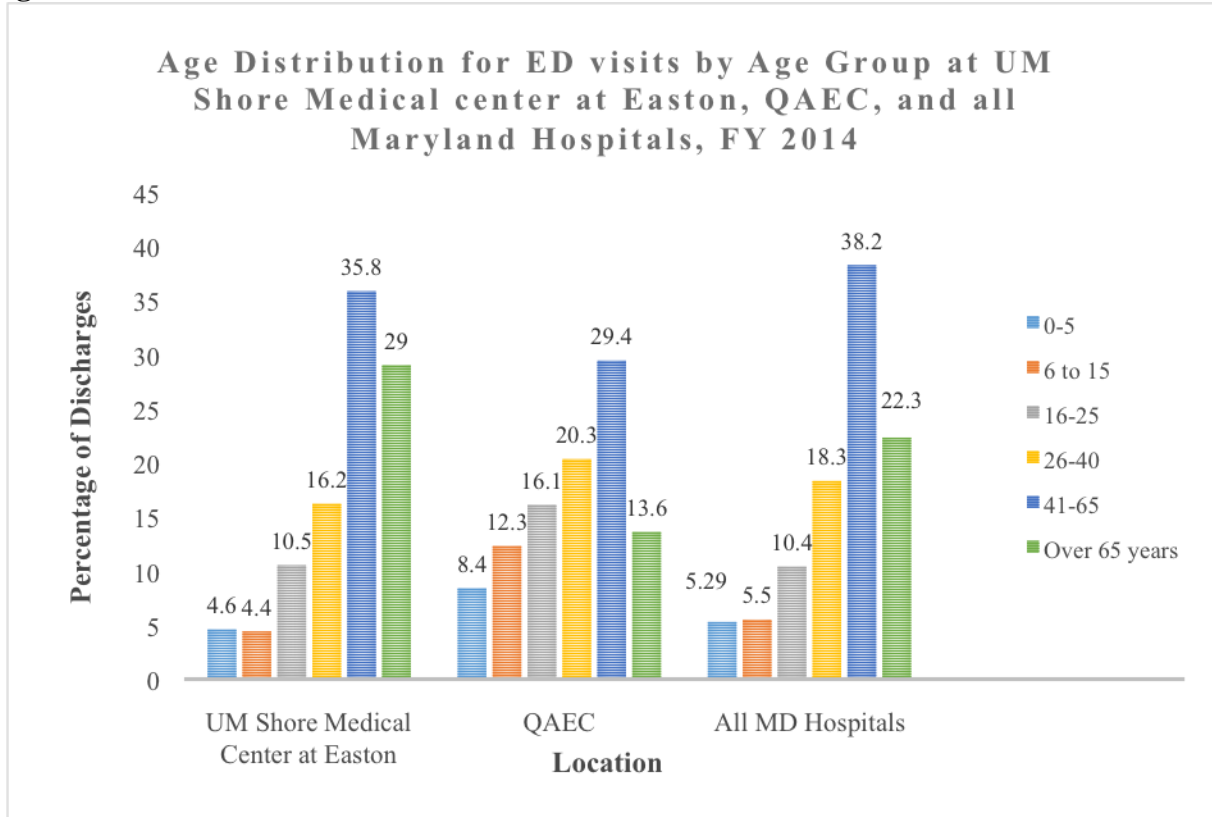
Table 13
Emergency Visits by Age Group: UM Shore Medical Center at Easton ED, Queen Anne's
Emergency Center, and Maryland Hospitals, Fiscal Years 2013 and 2014

Year and Age Group (in years)	Number of Visits			Percentage of Visits		
	UM Shore Medical Center at Easton	QAEC	All Maryland Hospitals	UM Shore Medical Center at Easton	QAEC	All Maryland Hospitals
Fiscal Year 2013						
0-5 years	2,831	1,279	318,998	4.6	9.1	5.7
6-15 years	6,286	1,648	318,750	10.2	11.7	5.7
16-25 years	10,059	2,233	607,764	16.2	15.9	10.8
26-40 years	22,758	2,739	1,028,147	36.8	19.5	18.3
41-65 years	2,727	4,350	2,147,435	4.4	30.9	38.2
Over 65 years	17,264	1,810	1,204,339	27.9	12.9	21.4
Total	61,925	14,059	5,625,433	100%	100%	100%
Fiscal Year 2014						
0-5 years	2,458	1,209	294,996	4.6	8.4	5.3
6-15 years	5,669	1,781	306,867	10.5	12.3	5.5
16-25 years	8,754	2,321	579,837	16.2	16.1	10.4
26-40 years	19,307	2,929	1,023,005	35.8	20.3	18.3
41-65 years	2,355	4,238	2,131,897	4.4	29.4	38.2
Over 65 years	15,362	1,957	1,242,384	28.5	13.6	22.3
Total	53,905	14,435	5,578,986	100%	100%	100%

Sources: MHCC staff analysis of freestanding medical facilities data for Queen Anne's Emergency Center; MHCC staff analysis of outpatient data for Maryland hospitals.

Note: Emergency visits resulting in referral and admission to an acute care hospital are not included.

Figure 5



Source: MHCC staff analysis of HSCRC outpatient data and freestanding medical facilities data.

Registration Time

The mode of arrival for patients at the Queen Anne's Emergency Center is not available. However, the time of arrival for FY 2012 to FY 2014 is shown in Table 14. An analysis of discharged visits from the Queen Anne's Emergency Center by registration time shows that approximately 90 percent of visits occurred over the 16-hour period between 8:00 am and midnight for all three years reported.

Table 14
Discharged Visits by Registration Time:
Queen Anne's Emergency Center, Fiscal Years 2012-2014

Mode of Arrival	Number of Visits by Registration Time			Total	Percent Visits by Registration Time			Total
	Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight		Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight	
Fiscal Year 2011	942	3,865	4,654	9,461	10.0	40.9	49.2	100%
Fiscal Year 2012	1,318	3,859	7,926	13,103	10.1	29.4	60.5	100%
Fiscal Year 2013	1,328	4,155	8,111	13,594	9.8	30.6	59.7	100%
Fiscal Year 2014	1,306	4,317	8,375	13,998	9.3	30.8	59.8	100%

Source: MHCC staff analysis of freestanding medical facilities data.

Patient Acuity

Table 15 shows how the proportion of low, high, and moderate acuity cases has changed at Queen Anne's Emergency Center since its first full year of operation, FY 2011. In FY 2011, 2.0% of emergency visits at Queen Anne's Emergency Center were classified as non-urgent with minor problems (Level I) and 17.2% were classified as Level II, which also are low acuity visits. This is a much higher proportion of visits than in subsequent years. In both FY 2012 and FY2013, less than one-tenth of a percent of visits were classified as Level I, and less than two percent of visits were classified as Level II. In conjunction with decrease in low acuity visits, the proportion of visits classified as moderate acuity, Level III, increased over the same period, from 53.1% in 2011 to 69.5% in 2014. The proportion of high acuity visits changed only slightly over this period. In FY 2011, approximately 21.4% of visits were classified as Level IV compared to 20.8% in FY 2014. For the highest acuity category (Level V), the proportion of these visits at Queen Anne's Emergency Center decreased from 4.7% in FY 2011 to 3.4% in FY 2014.

Table 15
Percentage of Cases by Patient Acuity Level:
Queen Anne's Emergency Center, Fiscal Years 2011-2014

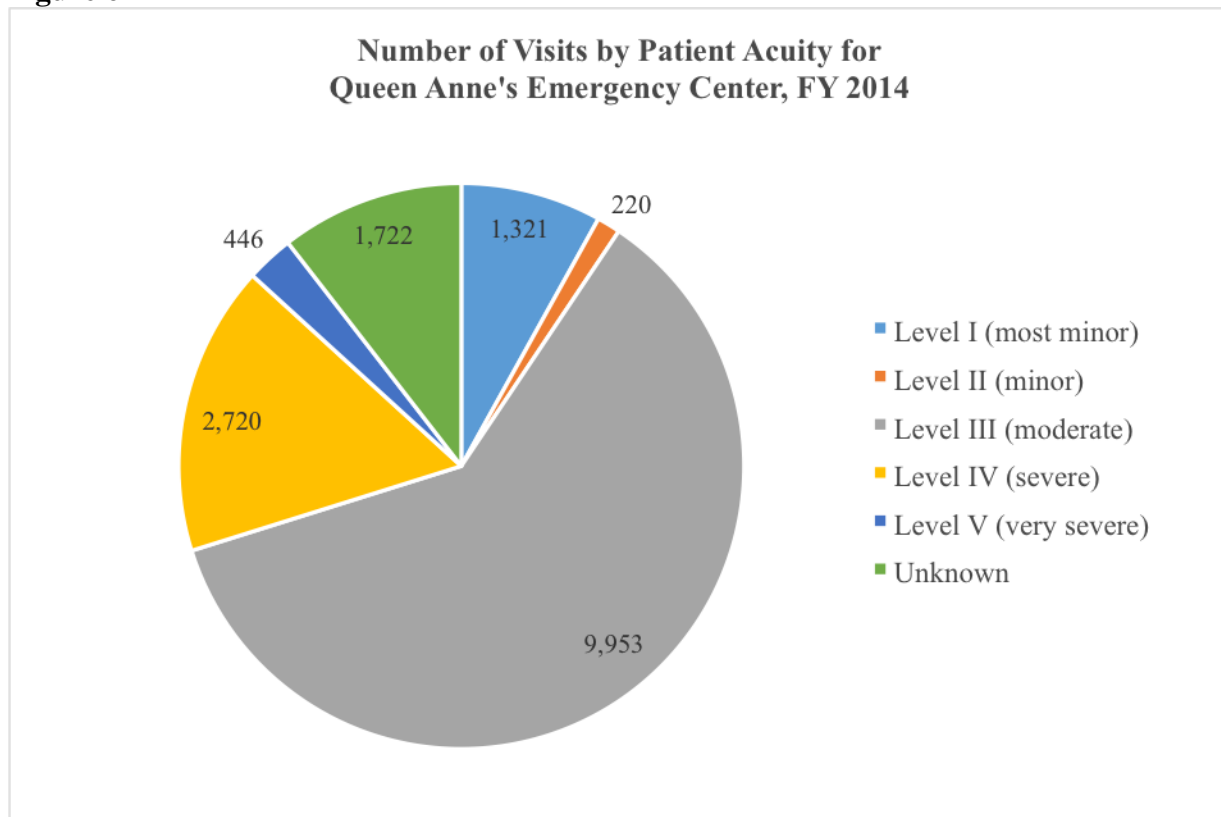
Acuity	2011	2012	2013	2014
Level I	2.0	< 0.1	< 0.1	4.7
Level II	17.2	0.8	1.7	1.6
Level III	53.1	67.1	78.3	69.5
Level IV	21.4	28.1	17.5	20.8
Level V	4.7	3.7	2.5	3.4
Unknown	1.6	0.2	< 0.1	< 0.1
All	100.0	100.0	100.0	100.0

Source: MHCC staff analysis of freestanding medical facilities data. Note: This analysis includes all visits for Queen Anne's Emergency Center, including those resulting in admission to an acute care hospital.

Note: Percentages are rounded to the nearest one-tenth percent; values greater than zero and less than one-tenth percent are indicated rather than rounded to zero.

The number of visits at Queen Anne's Emergency Center in FY 2014, with the proportion of visits classified by acuity level, is shown in Figure 6.

Figure 6



Source: MHCC staff analysis of freestanding medical facilities data, FY 2014

Compared to UM Shore Medical Center at Easton and other UM Shore System hospitals, Queen Anne's Emergency Center has a much smaller proportion of high acuity cases. As shown in Table 25, 20.8% of visits at Queen Anne's Emergency Center were classified as Level IV compared to 30.9% of visits at UM Shore Medical Center at Easton and 38.8% of visits at other UM Shore Medical Center Hospitals, in FY 2014. This pattern also holds for previous years, as shown in Tables 16 and 17.

Table 16
Percentage of Case by Patient Acuity Level:
UM Shore Medical Center at Easton, Fiscal Years 2008- 2014

Acuity	2008	2009	2010	2011	2012	2013	2014
Level I	6.3	4.4	3.3	3.2	0.1	0.1	4.1
Level II	19.7	18.8	16.4	13.1	1.9	2.1	2.9
Level III	38.0	39.1	39.4	40.8	52.2	62.9	56.8
Level IV	30.3	30.8	31.7	33.2	39.6	29.8	30.9
Level V	5.6	7.0	9.1	9.8	6.1	4.9	5.2
Unknown	<0.1	<0.1	<0.1	<0.1	0.1	0.2	0.2
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: MHCC staff analysis of outpatient data for UM Shore Medical Center at Easton.

Note: Percentages are rounded to the nearest one-tenth percent; values greater than zero and less than one-tenth percent are indicated rather than rounded to zero.

Table 17
Percentage of Visits by Patient Acuity Level:
Other UM Shore Hospitals, Fiscal Years 2008- 2014

Acuity	2008	2009	2010	2011	2012	2013	2014
Level I	7.1	3.5	1.4	1.1	0.1	0.0	4.1
Level II	25.2	23.9	17.3	15.1	2.4	2.1	2.5
Level III	34.4	43.4	48.3	46.8	48.4	58.7	50.9
Level IV	21.5	22.2	27.6	30.5	43.9	36.8	38.8
Level V	11.4	7.0	5.4	6.3	5.2	2.3	3.7
Unknown	0.4	0.1	<0.1	0.2	0.1	0.1	0.1
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: MHCC staff analysis of outpatient data for UM Shore Medical Center at Chestertown and UM Shore Medical Center at Dorchester.

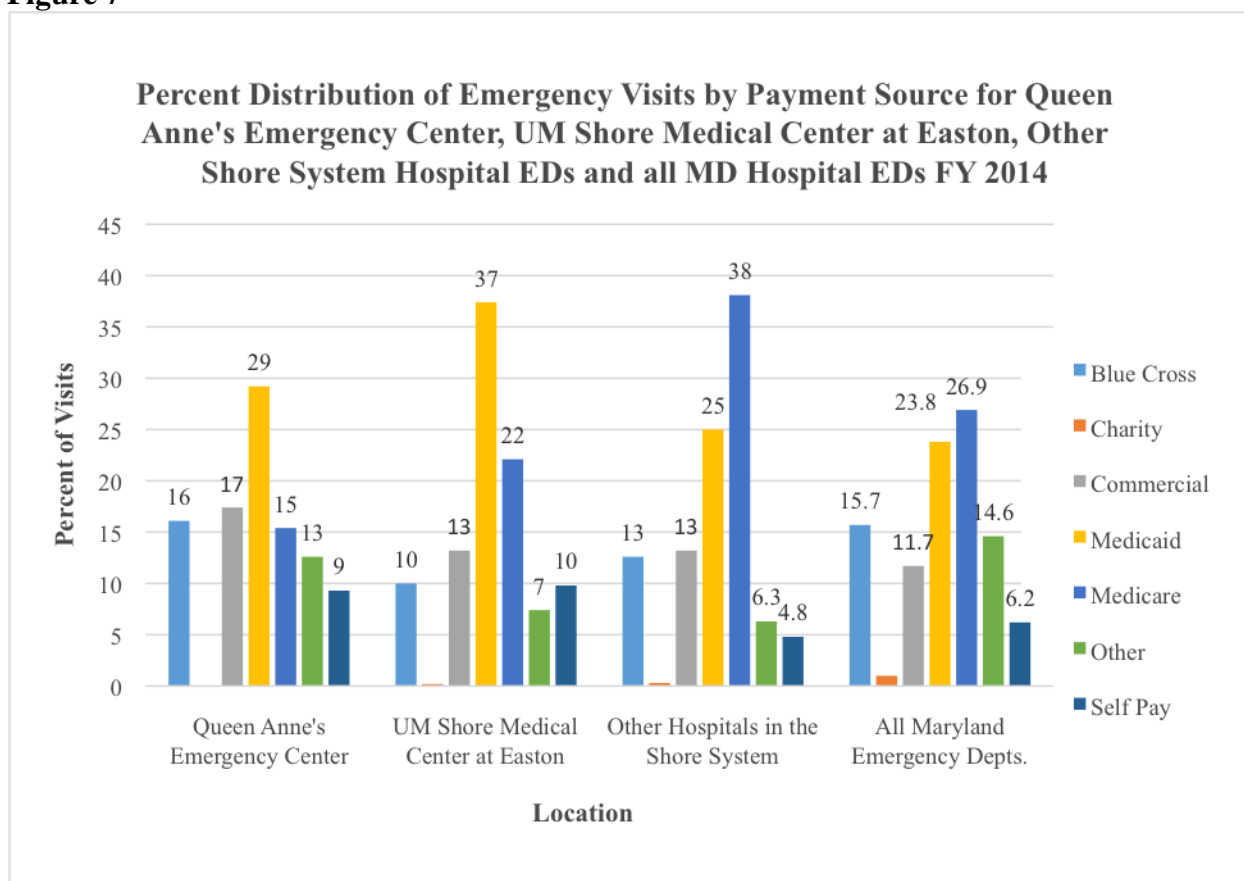
Note: Percentages are rounded to the nearest one-tenth percent; values greater than zero and less than one-tenth percent are indicated rather than rounded to zero.

Payment Sources

Figure 7 shows comparative information for the payment source of emergency visits at Queen Anne's Emergency Center, UM Shore Medical Center at Easton, other UM Shore Medical Centers, and all Maryland Hospital EDs, for FY 2014. In FY 2014, the most frequent payment source for emergency visits at Queen Anne's Emergency Center was the Medicaid program (29.6%). The proportion of Medicaid recipients at Queen Anne's Emergency Center is

much lower compared to UM Shore Medical Center at Easton (37.4%). However, the proportion of emergency visits at Queen Anne's Emergency Center was higher than for other UM Shore System hospitals' emergency departments (24.6%) and as compared to the statewide average for all hospital EDs (23.8%).

Figure 7



Sources: MHCC staff analysis of freestanding medical facilities data for Queen Anne's Emergency Center; MHCC staff analysis of outpatient data for Maryland hospitals.

Note: Visits resulting in referral and admission to an acute care hospital are not included.

The proportion of emergency visits at Queen Anne's Emergency Center with Medicaid as the payer source has increased slightly since FY 2012, from 26.2% to 29.6% in FY 2014. For FY 2011, reliable information is not available since many of the Center's records had payer source coded as unknown. For UM Shore Medical Center at Easton, the proportion of visits with Medicaid as the payer source increased by over 20% from FY 2008 to FY 2009, and from FY 2009 to FY 2010. However, the proportion of visits with Medicaid as the payer remained about the same for the next few years, before increasing by about 9% from FY 2013 to FY 2014.

With regard to Medicare, in FY 2014, both UM Shore Medical Center at Easton and Queen Anne's Emergency Center had a lower percentage of emergency visits with Medicare as the payer source, 15.4% and 22.1% respectively, as compared to the other UM Shore Medical Centers (37%) and the statewide average for all Maryland hospital EDs (26%). However, at UM Shore Medical Center at Easton, the percentage of emergency visits with Medicare as the payer

source has increased since FY 2008, when only 16.1% of visits had Medicare as the payer source.

Table 18 includes detailed information on the payer sources for emergency visits not resulting in referral and admission to an acute care hospital for Queen Anne's Emergency Center, other UM Shore System hospitals, and statewide for all Maryland hospital EDs. As shown in Table 24, Queen Anne's Emergency Center provided charity care to very few patients in both FY 2013 and FY 2014. In FY 2014, both Shore Medical Center at Easton and other Shore System hospitals also reported a low level of charity care, 0.2% and 0.3% respectively. This amount of charity care was also less than the statewide average for Maryland hospital EDs in FY 2014 (1%). In FY 2014, Queen Anne's Emergency Center reported a similar percentage of visits with the payer source listed as self-pay (9.3%), as compared to the percentage of visits for Shore Medical Center at Easton (9.8%). The percentage of self-pay visits for other Shore System hospitals was much lower (4.8%).

Table 18
Discharged Visits by Payment Source: UM Shore Medical Center at Easton, Queen Anne's
Emergency Center, Other Shore System Hospitals, and All Maryland Hospital EDs, Fiscal
Years 2013-2014

Payment Source	Visits by Payment Source				Percentage of Visits by Payment Source			
	Shore Medical Center at Easton ED	QAEC	Other Shore System Hospital EDs	All MD Hospital EDs	Shore Medical Center at Easton ED	QAEC	Other Shore System Hospital EDs	All MD Hospital EDs
Fiscal Year 2013								
Blue Cross	3,397	2,461	10,271	914,533	10.6	17.5	13.3	16.2
Charity	85	11	491	72,069	< 0.1	-	0.6	1.3
Commercial	4,379	2,437	10,675	673,010	13.7	17.4	13.8	12.0
Medicaid	10,983	3,811	16,936	1,241,314	34.3	27.1	22.0	22.1
Medicare	6,609	2,075	28,246	1,461,294	20.7	14.5	37.0	26.0
Other	2,346	1,737	5,349	820,395	7.3	12.4	6.9	14.6
Self-Pay	4,196	1,508	5,229	432,402	3.1	10.7	6.8	7.7
Unknown				10,416				
Total	31,997	14,040	77,197	5,625,433	100%	100%	100%	100%
Fiscal Year 2014								
Blue Cross	2,996	2,323	8,966	878,643	10.0	16.1	12.6	15.7
Charity	59	2	254	52,220	0.2	-	0.3	1.0
Commercial	3,934	2,497	9,406	655,028	13.2	17.4	13.2	11.7
Medicaid	11,163	4,195	17,529	1,326,557	37.4	29.2	25.0	23.8
Medicare	6,598	2,224	27,094	1,503,393	22.1	15.4	38.1	26.9
Other	2,201	1,816	4,459	814,621	7.4	12.6	6.3	14.6
Self-Pay	2,931	1,334	3,415	347,840	9.8	9.3	4.8	6.2
Unknown				672				
Total	29,882	14,391	71,123	5,578,974	100%	100%	100%	100%

Sources: MHCC staff analysis of freestanding emergency facilities data; MHCC staff analysis of outpatient data for Maryland hospitals.

Note: Percentages are rounded to the nearest one-tenth percent; values greater than zero and less than one-tenth percent are indicated rather than rounded to zero.

Financial Performance

The Queen Anne's Emergency Center has only operated as a rate regulated facility. As a result, the impact of rate regulation on the financial performance of Queen Anne's Emergency Center cannot be evaluated through comparing its financial performance before and after rate regulation.

As shown in Table 19, during all three full fiscal years that Queen Anne's Emergency Center has operated, there was a net loss of income ranging from approximately \$1.9 million in FY 2012 to \$ 3.5 million in FY 2013. As shown in Table 20, the revenue per visit at Queen Anne's Emergency Center was approximately \$300 for FY 2011-FY 2013, and the cost per visit ranged from \$448 to \$539 dollars. As a result, the net loss per visit ranged from \$142 per visit to \$251 per visit for this period.

Table 19
Financial Performance and Number of Visits:
Queen Anne's Emergency Center, Fiscal Years 2011-2013

	2011	2012	2013
Gross revenue	\$ 2,953,000	\$ 4,381,000	\$ 4,128,000
Charity	\$29,000	\$8,000	\$158,000
Bad debt	\$ 89,000	\$ 240,000	\$ 89,000
Net revenue	\$ 2,864,000	\$ 4,141,000	\$ 4,039,000
Expenses	\$ 5,052,000	\$ 6,066,000	\$ 7,563,000
Income	\$ (2,188,000)	\$ (1,925,000)	\$ (3,524,000)
Visits	9,461	13,589	14,059

Sources: Financial information is from copies of financial statements obtained from HSCRC for FY 2011-13. The total number of visits is based on MHCC analysis of the freestanding medical facilities data. Additional information regarding the method of accounting of expenses in FY 2013 was provided by representatives for Shore Regional Health through email and phone correspondence on January 15th and 28th, 2015.

Notes: The fiscal year for QAEC begins July 1st and ends June 30th of the following calendar year. The first full fiscal year QAEC operated is FY 2011. In FY 2013, the reporting of expenses changed for QAEC. FY 2013 includes \$1.5 million in overhead for Shore Regional Health. While legally and technically correct to include this overhead for Shore Regional Health, FY 2011 and FY 2012 only include direct costs due to the financial relationship with the University of Maryland Medical System for this period. In order to consistently compare the expenses and net income at QAEC across years, \$1.5 million in overhead should be removed as an expense in FY 2013, and \$1.5 million should be added to the net income included in this table for FY 2013.

Table 20
Per Visit Costs and Revenue:
Queen Anne's Emergency Center, Fiscal Years 2011-13

	2011	2012	2013
Gross revenue	\$312	\$323	\$294
Charity	\$3	\$1	\$11
Bad debt	\$9	\$18	\$6
Net revenue	\$303	\$306	\$288
Expenses	\$534	\$448	\$539
Income	\$(231)	\$(142)	\$(251)

Sources: Financial information is from copies of financial statements obtained from HSCRC for FY 2011-13. The total number of visits is based on MHCC analysis of the freestanding medical facilities data. Additional information regarding the method of accounting of expenses in FY 2013 was provided by representatives for Shore Regional Health through email and phone correspondence on January 15th and 28th, 2015.

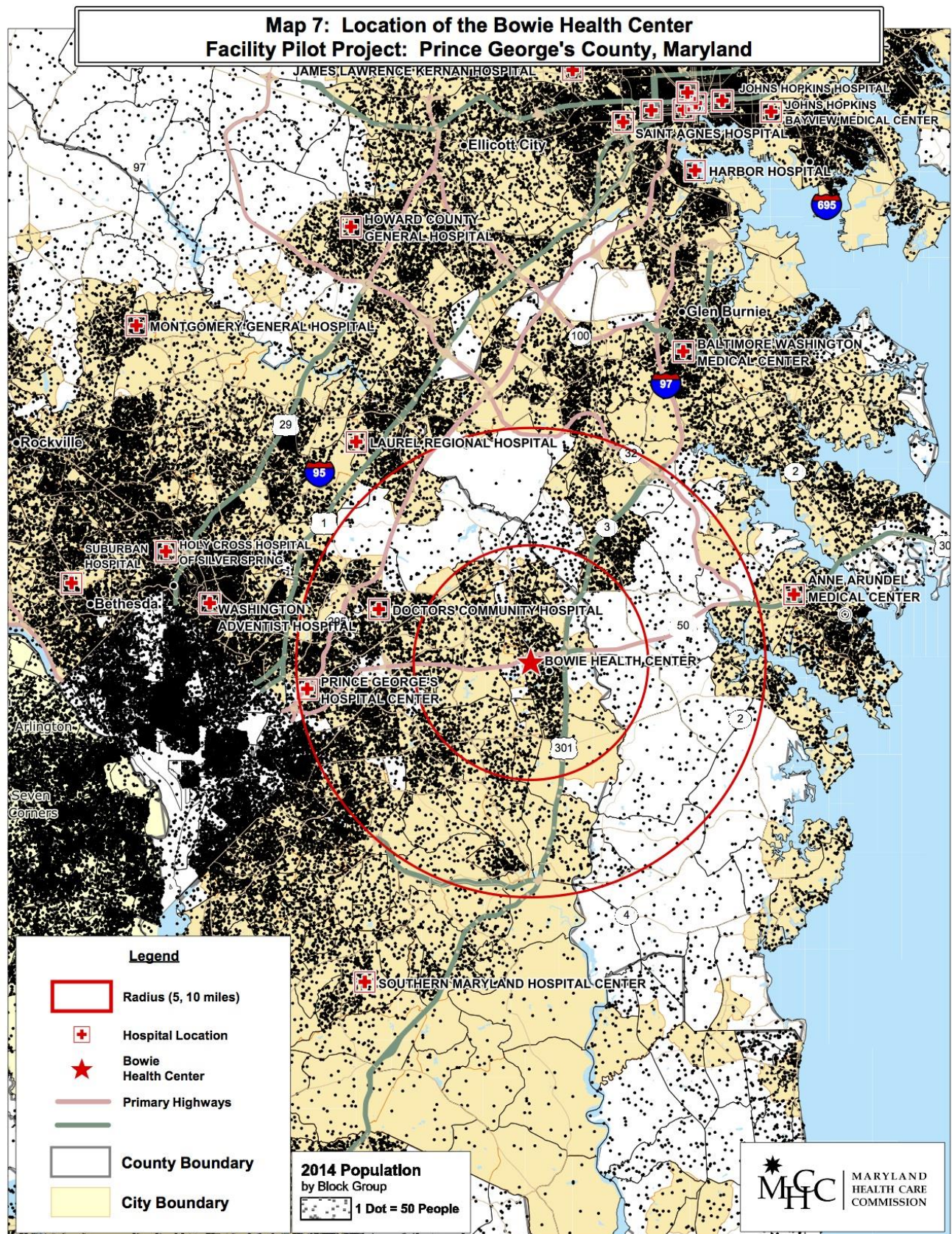
Notes: The fiscal year for QAEC begins July 1st and ends June 30th of the following calendar year. The first full fiscal year QAEC operated is FY 2011. In FY 2013, the reporting of expenses changed for QAEC. FY 2013 includes \$1.5 million in overhead for Shore Regional Health. While legally and technically correct to include this overhead for Shore Regional Health, FY 2011 and FY 2012 only include direct costs due to the financial relationship with the University of Maryland Medical System for this period. In order to consistently compare the expenses and net income at QAEC per case across years, \$1.5 million in overhead should be removed as an expense in FY 2013, and the expense per case and net income per case should be recalculated for FY 2013. The resulting revised expense per case in FY 2013 is \$431 and the revised income per case is \$(144).

Comparing the performance of Queen Anne's Emergency Center to the emergency department at UM Memorial Hospital at Easton is not possible because cost reports are only available for the hospital as a whole. However, based solely on the higher volume of visits for the hospital and the greater percentage of visits that result in referral and admission to the hospital, it might be expected to perform better financially as compared to the Queen Anne's Emergency Center.

Bowie Health Center

The Bowie Health Center was established under the auspices of the Prince George's Hospital Center, which is a part of Dimensions Health System. The Center is located on a 50-acre property at 15001 Health Center Drive in Bowie, Maryland. The site also includes a freestanding ambulatory surgical facility, Dimensions Surgery Center, a comprehensive care facility (nursing home), Larkin Chase Care and Rehabilitation Center, and a medical office building. There are seven hospitals, located in three jurisdictions, within 20 miles of the Bowie Health Center and 11 additional Maryland hospitals are within 30 miles. Map 7 shows the location of the Bowie Health Center in relation the Prince George's Hospital Center as well as other hospitals within a forty mile radius of the center.

Table 21 shows the driving distances from the Bowie Health Center to general hospitals. Bowie Health Center is located closest to Doctors Community Hospital (9.2 miles). The second closest general hospital is the FMF's parent hospital, Prince George's Hospital Center (10.6 miles). Anne Arundel Medical Center is approximately 12.8 miles from Bowie Health Center.



Source: Spatial Insights, Inc.

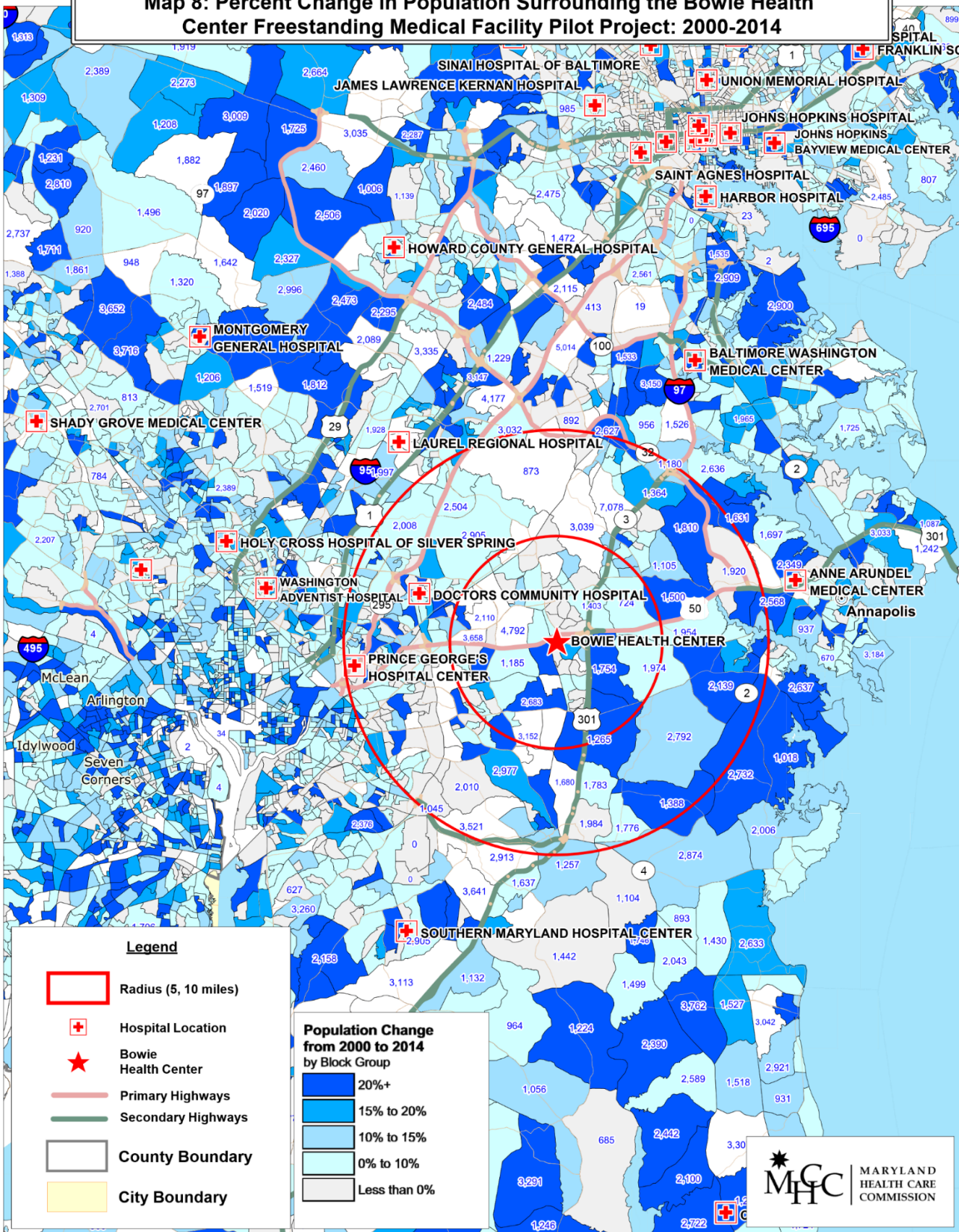
Table 21
Estimated Driving Distance from Nearby General Hospitals to Bowie Health Center

Hospital	Driving Distance (in miles)
Doctors Community Hospital	9.2
Prince George's Hospital Center	10.6
Anne Arundel Medical Center	12.8
Laurel Regional Hospital	15.4
Adventist HealthCare Washington Adventist Hospital	15.6
UM Baltimore Washington Medical Center	18.5
Holy Cross Hospital of Silver Spring	19.7
MedStar Southern Maryland Hospital Center	22.5
Suburban Hospital	25.0
Howard County General Hospital	26.5
Harbor Hospital	27.0
Fort Washington Medical Center	28.3
MedStar Montgomery General Hospital	29.0
Saint Agnes Hospital	29.9
University of Maryland Medical Center	30.1
Mercy Medical Center	30.1
The Johns Hopkins Hospital	30.7
University of Maryland Medical Center Midtown	30.8
Bon Secours Hospital	31.4
Johns Hopkins Bayview Medical Center	31.8
MedStar Union Memorial Hospital	33.0
UM Rehabilitation and Orthopaedic Institute (No ED)	33.7
Adventist HealthCare Shady Grove Medical Center	33.9
Calvert Memorial Hospital	34.0
MedStar Good Samaritan Hospital	35.8
Queen Anne's Emergency Center	36.6
UM Saint Joseph Medical Center	36.7
Sinai Hospital of Baltimore	36.8
Greater Baltimore Medical Center	37.5
Northwest Hospital Center	39.5
MedStar Franklin Square Hospital Center	39.5

Source: Spatial Insights, Inc.

Within the five mile radius surrounding the Bowie Health Center, there are about 113,758 residents. The estimated population increases to about 482,842 within a 10-mile radius of the facility. Map 8 shows patterns of population growth between 2000 and 2013 in the areas surrounding the Bowie Health Center.

Map 8: Percent Change in Population Surrounding the Bowie Health Center Freestanding Medical Facility Pilot Project: 2000-2014



Source: Spatial Insights, Inc.

An examination of the age composition of the population residing within a five-mile radius of Bowie Health Center shows that the percentage of the population under age 18 (24.5%) is only slightly higher than the statewide average (24%). The proportion of the population living around the Bowie Health Center that is 65 years and older (13.2%) is similar to the statewide average (13.4%).

In FY 2014, Prince George's Hospital Center's ED had the second highest volume of ED visits among Prince George's County hospitals (50,234). MedStar Southern Maryland Hospital Center, with 59,128 visits, had the busiest ED in the jurisdiction. With the exception of Prince George's Hospital Center, the volume of ED visits at hospitals in Prince George's County was lower in 2014 than in 2009. The volume of visits also declined at Bowie Health Center in FY 2014 as compared to FY 2009, although there was not a consistent downward trend in volume. The number of emergency department visits increased by 11.6 percent at Prince George's Hospital Center in this five year period.

Patient Volumes and Admission for Inpatient Care

The Bowie Health Center was licensed by the Office of Health Care Quality as a freestanding medical facility in June 2007. However, it operated for almost 30 years prior to its licensure as an FMF. For the last few years, visits to the Bowie Health Center have averaged approximately 36,000 per year; Table 30 shows the volume of visits for the period FY 2011 to FY 2014. In FY 2014, the total number of visits (35,344) was approximately 4.0% lower than for FY 2013 (36,811). In FY 2014, the Bowie Health Center had an average of 96.8 visits per day.

The majority of patients visiting the Bowie Health Center are discharged to home following treatment. As shown in Table 22, in FY 2014, approximately 94% of all patients seen at Bowie Health Center were discharged to home. Patient requiring admission for inpatient care at Prince George's Hospital Center or other acute care hospitals in the area accounted for approximately 6% of all visits to the Bowie Health Center in FY 2014.

Table 22
Number and Percent Distribution of Visits by Disposition:
Bowie Health Center (BHC), Fiscal Years 2012-2013

Fiscal Year	Patient Disposition		Total BHC Patients	% Distribution		Total BHC Patients
	Admitted to Other Acute Care Hospitals	Discharged from BHC		Admitted to PGHC or Other Acute Care Hospitals	Discharged from BHC	
2011	1,279	33,894	35,173	3.6%	96.4%	100.0%
2012	1,548	34,446	36,164	4.8%	95.3%	100.0%
2013	1,787	34,850	36,811	5.3%	94.7%	100.0%
2014	2,087	33,257	35,344	5.9%	94.1%	100.0%

Source: Bowie Health Center Transfer Summary 2012 and 2013

Service Area

The extended service area of the Bowie Health Center partially overlaps with the service area for the Prince George's Hospital Center ED in fiscal year 2014, as shown in Table 23. The extended service area is defined as the zip code areas of residence for patients that when ordered from the most frequent to the least frequent are included in the top 85% of patient emergency department visits. The extended service area for the PGHC emergency department includes 26 zip code areas, compared to 19 zip code areas for Bowie Health Center. The overlapping service area accounts for approximately 65 percent of the total ED visits at Bowie Health Center. For Prince George's Hospital Center, the overlapping zip code areas account for 66% of total ED visits. Another hospital in Prince George's County, Doctors Community Hospital, also has an extended service area that overlaps just as extensively with Bowie Health Center. The overlap with the extended service area of Laurel Regional Hospital, the other Dimensions Health System hospital in Prince George's County, is approximately 27%. Map 9 displays the overlap of BHC's service area with Laurel Regional Hospital, Prince George's Hospital Center, and Doctors Community Hospital.

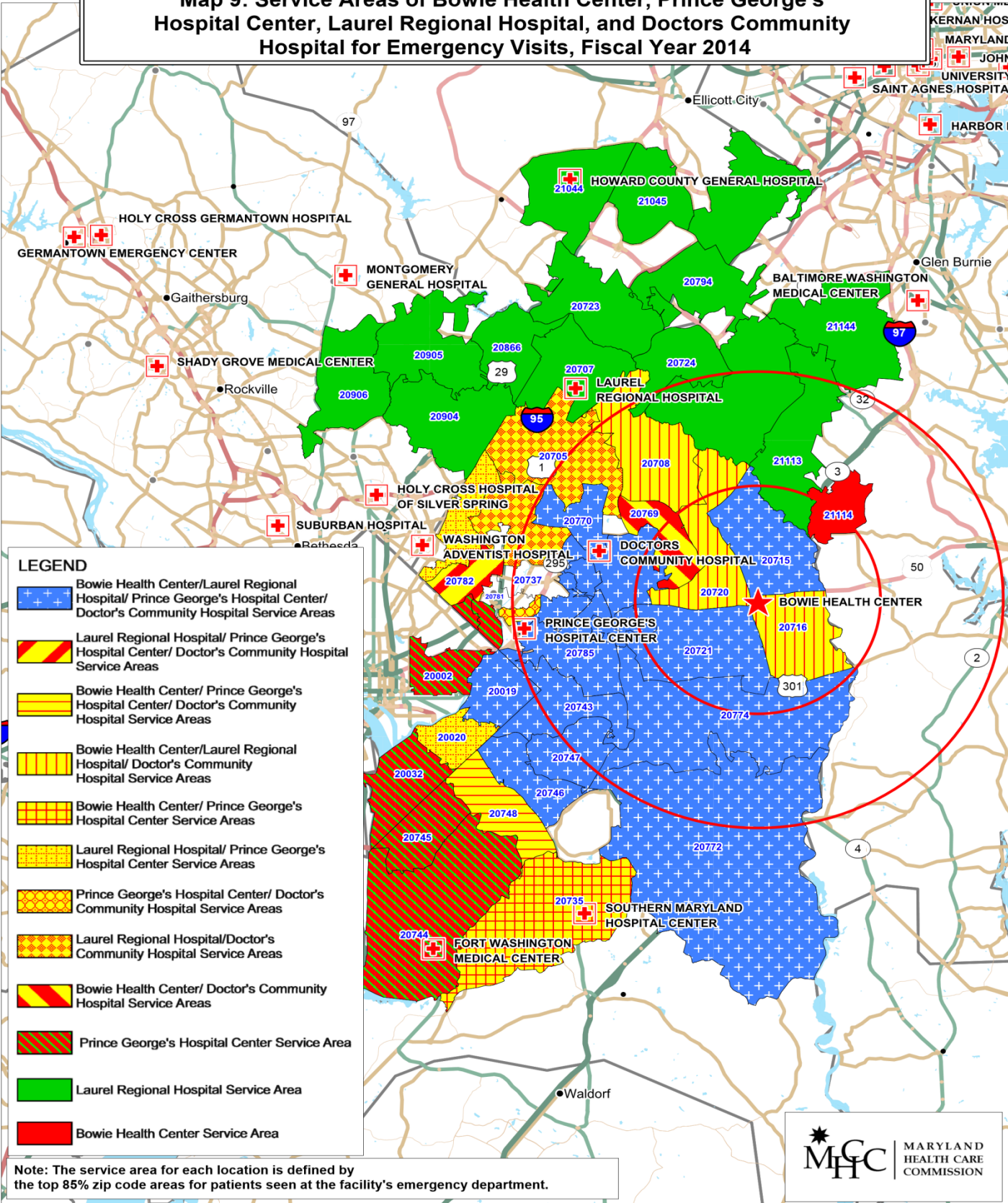
Table 23
Distribution of Visits by Zip Code Area of Patient Residence:
Prince George's Hospital Center and the Bowie Health Center, Fiscal Year 2014

Zip Code Area	Prince George's Hospital Center				Bowie Health Center			
	Visits	Percent of Total	Cumulative Percent	Rank	Visits	Percent of Total	Cumulative Percent	Rank
20785	7,754	15.4	15.4	1	2,098	5.9	5.9	7
20743	6,565	13.1	28.5	2	1,893	5.4	11.3	8
20784	3,392	6.8	35.3	3	710	2.0	13.3	11
20747	2,923	5.8	41.1	4	1,494	4.2	17.5	9
20019	2,908	5.8	46.9	5	546	1.5	19.0	12
20774	2,450	4.9	51.7	6	4,407	12.5	31.5	1
20706	1,791	3.6	55.3	7	1,437	4.1	35.6	10
20737	1,724	3.4	58.7	8				
20710	1,688	3.4	62.1	9				
20746	1,253	2.5	64.6	10	411	1.2	36.7	14
20721	1,096	2.2	66.8	11	2,996	8.5	45.2	4
20781	978	2.0	68.7	12				
20020	833	1.7	70.4	13				
20772	820	1.6	72.0	14	2,825	8.0	53.2	5
20748	808	1.6	73.6	15	272	0.8	53.9	17
20782	780	1.6	75.2	16				
20770	662	1.3	76.5	17	393	1.1	55.1	15
20783	613	1.2	77.7	18				
20745	594	1.2	78.9	19				
20032	530	1.1	79.9	20				
20722	529	1.1	81.0	21				
20744	505	1.0	82.0	22				
20002	497	1.0	83.0	23				
20735	424	0.8	83.8	24	245	0.7	55.8	18
20712	345	0.7	84.5	25				
20715	323	0.6	85.2	26	3,079	8.7	64.5	3
20716					4,133	11.7	76.2	2
20720					2,258	6.4	82.6	6
20769					503	1.4	84.0	13
21114					329	.9	85.0	16
20708					232	0.7	85.6	19

Source: MHCC staff analysis of Freestanding Medical Facility Data, FY 2014.

Note: Percentages are rounded to the nearest one-tenth; values greater than zero and less than one-tenth are indicated instead of rounded to zero.

Map 9: Service Areas of Bowie Health Center, Prince George's Hospital Center, Laurel Regional Hospital, and Doctors Community Hospital for Emergency Visits, Fiscal Year 2014



Source: Spatial Insights, Inc.

Visits per Treatment Space

In 2013, the number of visits per treatment space at the Bowie Health Center (1,753) was above the statewide average and above the visits per treatment space at the Prince George's Hospital Center (1,114). The volume of ED visits at the Prince George's Hospital Center decreased by 82 visits per treatment space between 2012 and 2013, following the addition of three additional treatment spaces (Table 24).

Table 24
Total Visits, Treatment Spaces, and Visits per Treatment Space:
Prince George's Hospital Center ED, Bowie Health Center, and Maryland Hospital
Emergency Departments, Fiscal Years 2012 and 2013

Facility	Total Visits		Treatment Spaces		Visits Per Treatment Space	
	2012	2013	2012	2013	2012	2013
Prince George's Hospital Center	52,616	52,373	44	47	1,196	1,114
Bowie Health Center	36,164	36,812	21	21	1,722	1,753
All Maryland Hospital EDs	2,599,825	2,606,630	2,003	2,045	1,298	1,275

Sources: MHCC staff analysis of inpatient and outpatient data for Maryland hospitals for FY 2013; MHCC staff analysis of freestanding medical facilities data for Bowie Health Center; MHCC Supplemental Survey: Emergency Department Treatment Capacity as of June 1, 2013, *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2014*.

Patient Age

Both Bowie Health Center and the Prince George's Hospital Center ED provide emergency services to a population that is younger, as compared to the statewide average for hospital emergency departments. Table 25 provides comparative information on the age profile of patients discharged following treatment at Bowie Health Center, Prince George's Hospital Center, other hospitals in Prince George's County, and all Maryland hospitals' EDs for FY 2013 and FY 2014. The percentage of visits for patients age 65 and over was 9.3% for Bowie Health Center and 7.2% for Prince George's Hospital Center, but it was 22.3% on average for all Maryland hospitals' EDs, as shown in Figure 8 and Table 33. In addition, the percentage of visits for patients age 41 to 65 was lower for both Bowie Health Center and Prince George's Hospital Center, as compared to the statewide average for all Maryland hospitals' EDs. In FY 2014, the percentage of visits for patients age 41 to 65 was similar for Bowie Health Center and Prince George's Hospital Center, 31.7% and 31.5% respectively, but the statewide average for this age cohort is 38.2%.

Although both Bowie Health Center and Prince George's Hospital Center provide services to a younger population compared to the statewide average for hospitals' emergency departments, there are differences in the population each treats. In FY 2014, Bowie Health Center had a higher proportion of visits for patients age 15 and younger, about 18.1%, as compared to the proportion for Prince George's County Hospital, 9.0%.

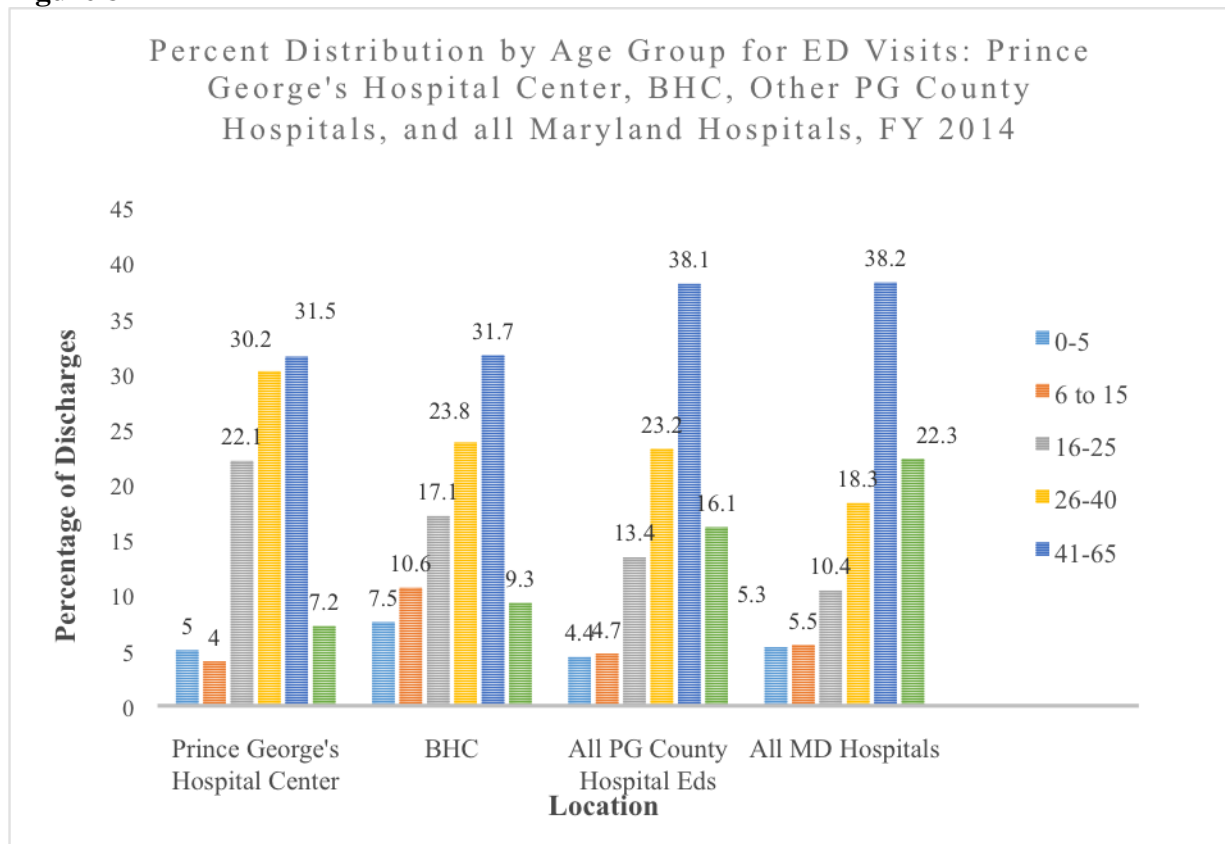
Table 25
Patients Discharged by Age Group: Prince George's Hospital Center ED, Bowie Health Center, and Maryland Hospital Emergency Departments, Fiscal Years 2013 and 2014

Year and Age Group (in years)	Discharged Patients			Percent Distribution by Age Group		
	Prince George's Hosp. Center ED	BHC	All Maryland Hospital EDs	Prince George's Hosp. Center ED	BHC	All Maryland Hospital EDs
FY 2013						
0-5 years	2,982	3,116	318,998	5.4	8.5	5.7
6-15 years	2,188	4,046	318,750	4.0	11.0	5.7
16-25 years	12,016	6,289	607,764	21.8	17.1	10.8
26-40 years	16,461	8,616	1,028,147	29.8	23.4	18.3
41-65 years	17,524	11,575	2,147,435	31.7	31.4	38.2
Over 65 years	4,076	3,169	1,204,339	7.4	8.6	21.4
Total	55,247	36,811	5,625,433	100%	100%	100%
FY 2014						
0-5 years	2,588	2,662	294,996	5.0	7.5	5.3
6-15 years	2,065	3,760	306,867	4.0	10.6	5.5
16-25 years	11,449	6,056	579,837	22.1	17.1	10.4
26-40 years	15,607	8,395	1,023,005	30.2	23.8	18.3
41-65 years	16,284	11,186	2,131,897	31.5	31.7	38.2
Over 65 years	3,720	3,285	1,242,384	7.2	9.3	22.3
Total	51,713	35,344	5,578,986	100%	100%	100%

Sources: MHCC staff analysis of freestanding medical facilities data; MHCC staff analysis of outpatient data for Maryland hospitals.

Note: Percentages were rounded to the nearest one-tenth percent.

Figure 8

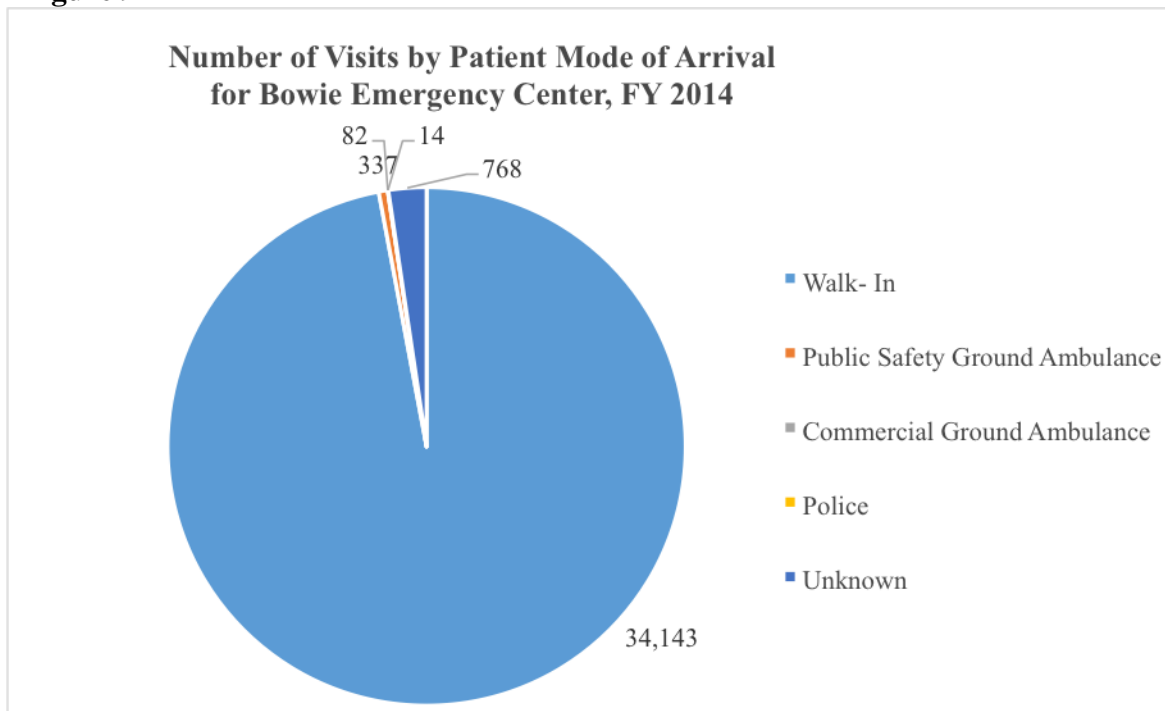


Source: MHCC staff analysis of HSCRC outpatient data and freestanding medical facilities data

Patient Mode of Arrival and Registration Times

The majority of patients (96.6%) arriving at the Bowie Health Center in 2014 were walk-in patients (34,143 total), as shown in Figure 9. The percentage of walk-in patients has declined slightly over the last several years. The average percentage of walk-in patients in FY 2010 and FY 2011 was 98.2%. In FY 2014, approximately one percent (337 patients) arrived at the Center via public safety ground ambulance. The mode of arrival for 873 patients (2%) is unknown. The mode of arrival at the Bowie Health Center for FY 2013 is shown in Figure 9. As shown in Table 26, patients seen at the Bowie Health Center most frequently registered between 4:01 pm and midnight in 2014 (54%). More than 88 percent of visits occur over the 16 hour period between 8:00 am and midnight. The proportion of patients registering during those hours has remained consistent since 2012.

Figure 9



Source: MHCC staff analysis of freestanding medical facilities data.

Table 26
Discharged Visits by Registration Time and Arrival Mode: Bowie Health Center, Fiscal
Years 2011 to 2014

Mode of Arrival and Fiscal Year	Number of Visits by Registration Time			Total	Percent Visits by Registration Time			Total
	Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight		Overnight 12:01am- 8:00am	Business 8:01 am- 4:00pm	Evening/Night 4:01pm- Midnight	
Fiscal Year 2011								
Walk-in	3,031	12,395	19,114	34,540	8.6	35.2	54.3	
Public Safety	46	29	84	159	0.1	0.1	0.2	
Ambulance								
Comm. Ambulance	1	2	9	12	0	< 0.1	< 0.1	
Police	2	2	5	9	0.01	< 0.1	< 0.1	
Unknown	148	97	208	453	0.4	0.3	0.6	
Total	3,228	12,525	19,420	35,173	9.2	35.6	55.21	100%
Fiscal Year 2012								
Walk-in	3,710	12,533	18,861	35,104	10.3	34.7	52.15	
Public Safety	24	12	74	110	0.1	< 0.1	0.2	
Ambulance								
Comm. Ambulance	4	2	7	13	< 0.1	0.01	<0.1	
Police	6	3	6	15	< 0.1	0.01	<0.1	
Unknown	195	240	487	922	0.5	0.7	1.35	
Total	3,939	12,790	19,435	36,164	10.9	35.4	53.74	100%
Fiscal Year 2013								
Walk-in	4,192	12,605	18,922	35,719	11.4	34.2	51.4	
Public Safety	61	46	100	207	0.2	0.1	0.3	
Ambulance								
Comm. Ambulance	3	.	2	5	< 0.1	.	< 0.1	
Police	6	.	1	7	< 0.1	.	< 0.1	
Unknown	235	163	475	873	0.6	0.4	1.3	
Total	4,497	12,814	19,500	36,811	12.2	34.8	53.0	100%
Fiscal Year 2014								
Walk-in	3,882	11,634	18,627	34,143	11.0	32.9	52.7	
Public Safety	100	109	128	337	0.3	0.3	0.4	
Ambulance								
Comm. Ambulance	1	7	74	82	0	< 0.1	0.2	
Police	7	1	6	14	< 0.1	0	< 0.1	
Unknown	174	221	373	768	0.5	0.6	1.1	
Total	4,164	11,972	19,208	35,344	11.8	33.9	54.4	100%

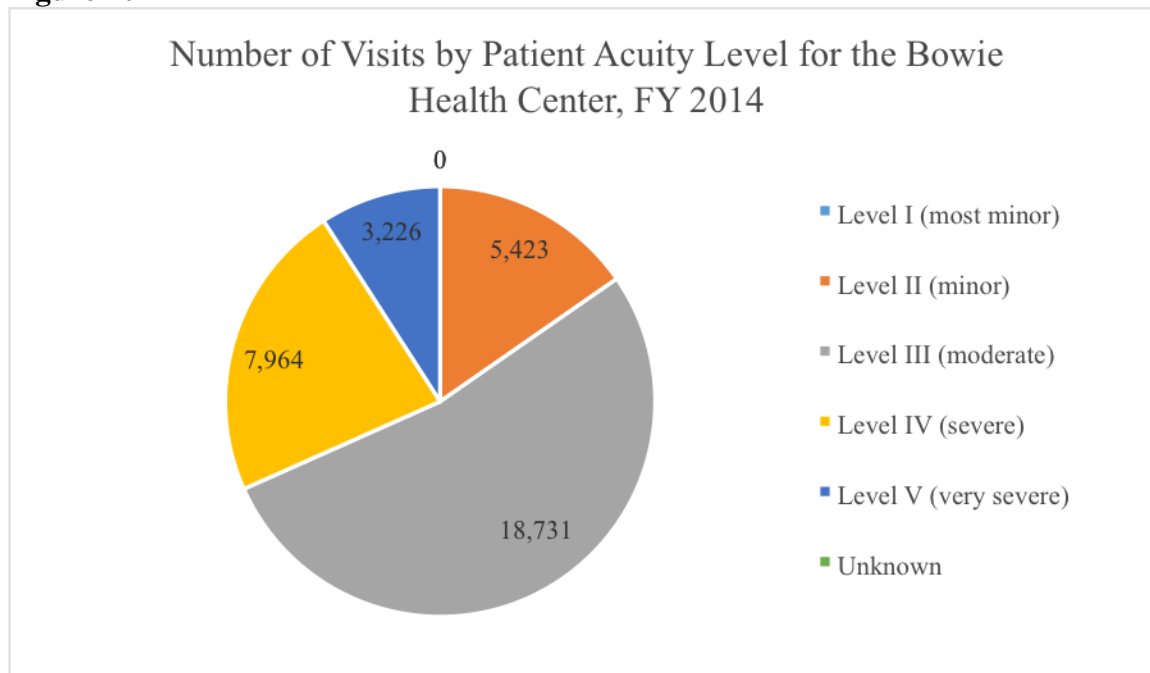
Source: MHCC staff analysis of freestanding medical facilities data.

Note: Percentages are rounded to the nearest one-tenth percent; values greater than zero and less than one-tenth percent are indicated rather than rounded to zero.

Patient Acuity

In FY 2014, none of the visits at Bowie Health Center in FY 2014 were classified as Level I, and only about 15 percent were classified as Level II acuity. This is a much lower proportion of Level I and Level II visits as compared to the proportion in FY 2008-FY 2010. During this period, although still very few patients were classified as Level I acuity, 80 percent or more were reported as being Level II acuity. In FY 2014, the acuity level of about 9% of the patients (3,226) was considered to be urgent, requiring immediate attention (Level V). Almost 23 percent (7,964) were level IV acuity. Most of patients seen at the Bowie Health Center (approximately 53%) were classified as Level III in FY 2014. This also represents a change from 2008-2010, when only about 10 percent of patients were reported to as having a moderate acuity level. The acuity level of patients seen in the Bowie Health Center can be seen in Figure 10. The percentage of cases by patient acuity level is shown in Table 27.

Figure 10



Source: MHCC staff analysis of Freestanding Medical Facility Data, FY 2014

Table 27
Percentage of Visits by Patient Acuity Level:
Bowie Health Center, Fiscal Years 2008-14

Acuity	2008	2009	2010	2011	2012	2013	2014
Level I	0.1	0.02	0.02	0.1	0.8	5.0	
Level II	82.4	81.8	79.3	78.0	74.0	56.1	15.3
Level III	10.2	9.6	10.8	10.3	11.1	22.0	53.0
Level IV	4.5	4.8	5.5	6.8	8.3	10.2	22.5
Level V	2.0	2.8	4.0	4.9	6.0	6.7	9.1
Unknown	0.9	1.0	0.5	0	0		
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: MHCC staff analysis of outpatient data for Bowie Health Center

As compared to Prince George's Hospital Center ED, as well as other hospital emergency departments in Prince George's County and Maryland hospital EDs collectively (Tables 28 and 29), the Bowie Health Center has fewer low acuity patients (levels I and II) as well as fewer high acuity patients (levels IV and V). However, the percentage of patients coded as moderate acuity (Level III) at BHC in 2014 is more than 20 percent greater than is reported by other hospital emergency departments in Prince George's County.

Table 28
Percentage of Visits by Patient Acuity Level:
Prince George's Hospital Center, Fiscal Years 2008- 2014

Acuity	2008	2009	2010	2011	2012	2013	2014
Level I	8.4	6.5	4.5	3.9	4.5	6.2	0.5
Level II	40.0	28.9	40.5	43.4	43.4	35.5	13.0
Level III	21.0	22.1	22.3	21.2	19.7	22.2	32.4
Level IV	13.5	18.1	13.7	12.3	11.9	14.0	17.0
Level V	16.5	23.9	18.3	18.2	19.7	21.4	35.8
Unknown	0.7	0.6	0.7	0.9	0.8	0.8	1.2
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: MHCC staff analysis of outpatient data for Prince George's Hospital Center ED

Table 29
Percentage of Visits by Patient Acuity Level:
Other Prince George's Co. Hospitals, Fiscal Years 2008- 2014

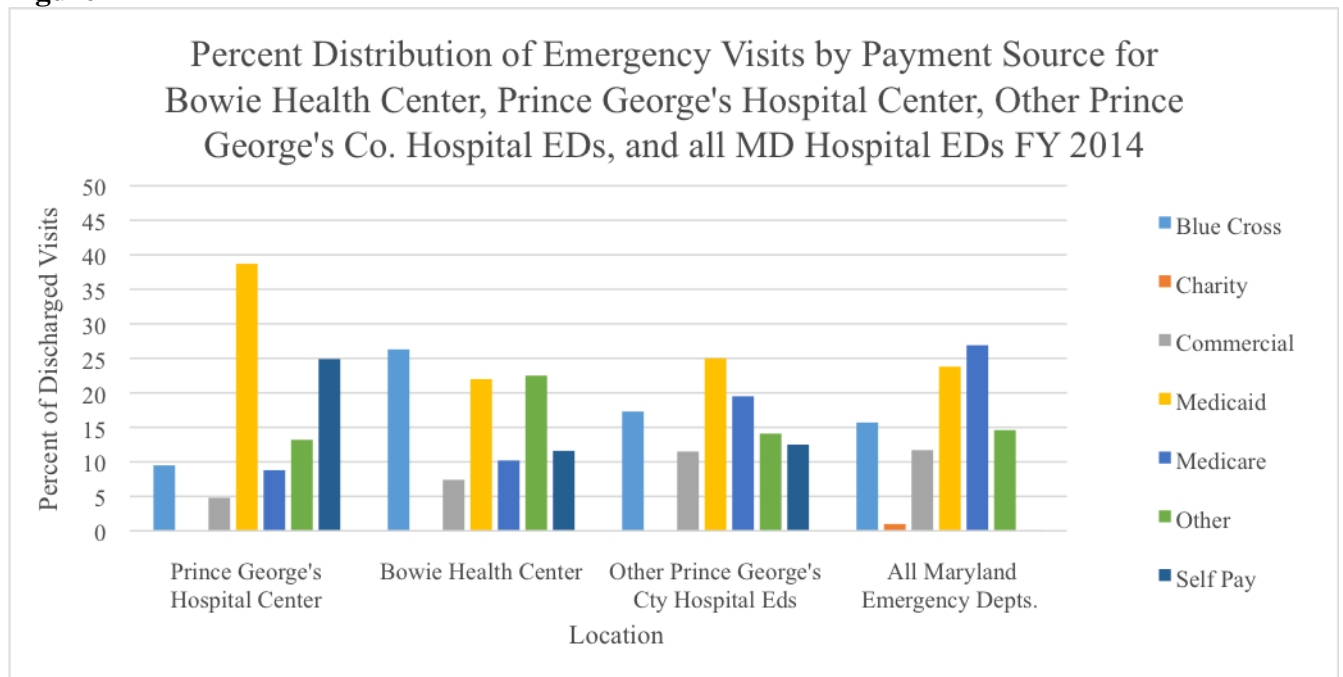
Acuity	2008	2009	2010	2011	2012	2013	2014
Level I	7.07	6.3	6.5	4.8	4.8	4.5	3.6
Level II	30.9	28.7	27.0	27.4	25.9	22.9	16.2
Level III	34.1	35.0	34.3	33.3	34.1	34.4	32.4
Level IV	20.6	21.7	22.9	23.7	24.8	27.8	29.6
Level V	7.3	8.3	9.2	10.6	10.3	10.1	17.8
Unknown	0.01	0.02	0.04	0.1	0.16	0.3	0.5
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: MHCC staff analysis of outpatient data for Other Prince George's County Hospital EDs

Payment Sources

Blue Cross was the leading payment source at the Bowie Health Center, accounting for more than one out of every four emergency department visits (26.3 percent). The Medicaid program was the leading source of payment at the Prince George's Hospital Center (38.7 percent) and at other Prince George's County emergency departments (25 percent) was. The most common payment source in all Maryland hospital emergency departments is the Medicare program (26.9 percent of discharged visits). The second and third most frequent sources of payment at the Bowie Health Center were "other" sources of payment (22.5 percent) and the Medicaid program (22.0 percent). Approximately 10 percent of the patients at the BHC were Medicare recipients, while 11.6 percent were self-pay. There were fewer patients with commercial payers at both the Bowie Health Center (7.4 percent) and at the Prince George's Hospital Center emergency department (4.8 percent) than at either other hospital emergency departments in Prince George's County (11.5 percent) or other emergency departments statewide (11.7%). The number of visits to the Bowie Health Center in 2014 by payer type can be seen in Figure 12, while a comparison of payer types among the Bowie Health Center, the Prince George's Hospital Center, other hospital emergency departments in Prince George's County, and other Maryland emergency departments can be seen in Table 30.

Figure 12



Sources: MHCC staff analysis of freestanding medical facilities data for Queen Anne's Emergency Center; MHCC staff analysis of outpatient data for Maryland hospitals.

Note: Visits resulting in referral and admission to an acute care hospital are not included.

Table 30
Discharged Visits by Payment Source: Prince George's Hospital Center, Bowie Health Center, Other Prince George's County Hospital EDs, and All Maryland Hospital EDs, Fiscal Years 2013-2014

Payment Source	Discharged Visits by Payment Source				% Distribution by Payment Source			
	Prince George's Hospital Center	Bowie Health Center	Other PG Co.Hosp. EDs	All MD Hospital EDs	Prince George's Hospital Center	Bowie Health Center	Other PG Co.Hosp. EDs	All MD Hospital EDs
Fiscal Year 2013								
Blue Cross	4,103	9,932	40,418	914,533	9.4	27.0	17.7	16.2
Charity	-	-	-	72,069	-	-	-	1.3
Commercial	2,455	2,887	26,084	673,010	5.6	7.8	11.4	12
Medicaid	15,668	7,244	50,322	1,241,314	35.9	19.7	22.0	22.1
Medicare	4,249	3,554	42,309	1,461,294	9.7	9.7	18.5	26
Other	5,468	8,612	35,708	820,395	12.5	23.4	15.6	14.6
Self-Pay	11,753	4,582	33,933	432,402	26.9	12.4	14.8	7.7
Unknown			2	10,416				
Total	43,696	36,811	228,776	5,625,433	100%	100%	100%	100%
Fiscal Year 2014								
Blue Cross	3,855	9,305	37,755	878,643	9.5	26.3	17.3	15.7
Charity	-	-	-	52,220	-	-	-	1.0
Commercial	1,969	2,603	25,190	655,028	4.8	7.4	11.5	11.7
Medicaid	15,738	7,764	54,736	1,326,557	38.7	22.0	25.0	23.8
Medicare	3,589	3,621	42,668	1,503,393	8.8	10.2	19.5	26.9
Other	5,377	7,959	30,831	814,621	13.2	22.5	14.1	14.6
Self-Pay	10,095	4,093	27,427	347,840	24.9	11.6	12.5	6.2
Unknown			12	672				
Total	40,623	35,345	218,619	5,578,974	100%	100%	100%	100%

Sources: MHCC staff analysis of freestanding emergency facilities data; MHCC staff analysis of outpatient data for Maryland hospitals.

Financial Performance

Unlike Germantown Emergency Center, which operated both before (2006-2011) and after it became rate regulated (July 1, 2011 to present) through the Health Services Cost Review Commission, BHC has only operated as a rate regulated facility, although the manner in which it has been rate regulated has changed. As a result, the impact of rate regulation on the financial performance of BHC cannot be evaluated through comparing its financial performance before and after rate regulation.

During the first two full fiscal years in which BHC has operated as a licensed FMF, it experienced a net loss of income. As shown in Table 31, in FY 2012 and FY 2013, BHC reported

net losses of approximately \$566,500 and \$945,000, respectively. These losses are equivalent to approximately seven to ten percent of net patient revenue. Negotiation of an FY 2014 global budget for Dimensions Health System modified the division of revenue for the System's components, boosting revenue for BHC. HSCRC modified the division of revenue based on its assessment that the facility was underpaid in previous years relative to the actual resources dedicated to patient care. This change led to positive income of \$1.9 million in FY 2014 for BHC, a margin of 15.7%.

Table 31
Bowie Health Center Financial Performance, FY 2012- FY 2014
(\$000s)

	2012	2013	2014
Gross patient revenue	\$11,999.9	\$13,677.9	\$16,513.4
Charity	756.0	1,021.2	1,013.8
Bad debt	1,806.2	2,074.1	2,162.5
Contractual adjustments and denials	734.5	840.8	937.4
Other deductions	26.3	(70.4)*	-
Net Revenue	8,676.9	9,812.2	12,399.7
Other operating revenue	13.1	7.2	0.9
Total net revenue	8,690.0	9,819.4	12,400.6
Expenses	9,256.5	10,764.4	10,457.2
Income	(\$566.5)	(\$945.0)	\$1,943.4
Visits	35,173	36,811	35,344

Source: Audited financial statements and MHCC staff analysis of freestanding medical facilities data sets.

*Note: Accrual to adjust net patient revenue based on billed charges to what the hospital believes to be the actual net patient revenue for the year.

Table 32
Bowie Health Center Per Visit Financial Performance, FY 2012- FY 2014

	2012	2013	2014
Gross revenue	\$341	\$372	\$467
Charity	21	28	29
Bad debt	51	56	61
Contractual adjustment and denials	21	23	27
Other deductions	1	(2)*	-
Net revenue	247	267	351
Other operating revenue	-	-	-
Total net revenue	247	267	351
Expenses	263	292	296
Income	(\$16)	(\$26)	\$55
Visits	35,173	36,811	35,344

Source: Audited financial statements and FMF data sets

*Accrual to adjust net patient revenue based on billed charges to what the hospital believes to be the actual net patient revenue for the year.

Appendix 5

Data Bases and Procedures for Data Collection and Reporting by Freestanding Medical Facilities

Background Regarding the MHCC's Freestanding Medical Facilities Data Base and COMAR 10.24.06

The MHCC adopted regulations, effective October 23, 2006, that identify two major categories of data to be reported to the Commission: facility-level or aggregate data; and, patient-level data. Within each category, the general types of information to be reported are described.

The Commission designed its patient-level freestanding medical facilities data to be consistent with the hospital outpatient data set for emergency department visits, although with several additional items: registration time; discharge time; mode of arrival; priority status for fire department ambulance transports; mode of departure; patient disposition at end of visit; acute care hospital transfer site ID; and type of service. The approach of using the existing hospital emergency department data set, supplemented with items specific to the freestanding emergency facility, facilitated implementation and had the advantage of providing a consistent data set across settings, thereby assisting the Commission in analyzing the experience at the pilot project in comparison with hospital-based emergency department services. The regulations follow.

COMAR 10.24.06: Data Reporting by Freestanding Medical Facilities

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

- (1) "Commission" means the Maryland Health Care Commission.
- (2) "Freestanding medical facility" has the meaning stated in Health-General Article, §19-3A-01, Annotated Code of Maryland, and COMAR 10.07.08.
- (3) "Freestanding medical facility pilot project" means one freestanding medical facility pilot project under Health-General Article, §19-3A-07, Annotated Code of Maryland.

.02 Collection and Reporting of Data.

A. A freestanding medical facility shall submit accurate, timely, and complete data which the Commission considers to be necessary for planning and analysis purposes, as requested by the Commission.

B. The information requested by the Commission may include, but is not limited to, the following types of information:

- (1) Aggregate facility data as follows:
 - (a) Service configuration;
 - (b) Location;
 - (c) Operational characteristics; and
 - (d) Utilization; and
- (2) Patient-level data as follows:
 - (a) Demographic characteristics;
 - (b) Admission, discharge, and disposition data;
 - (c) Diagnosis and treatment data; and
 - (d) Payment source and charges.

C. The Commission shall provide notice of the form, format, and schedule for data reporting by freestanding medical facilities.

D. Failure to report the data required under this regulation may subject a freestanding medical facility to penalties under COMAR 10.25.12.

E. Extension.

(1) A freestanding medical facility, by letter to the Executive Director of the Commission, may request an extension of its data submission date.

(2) The Executive Director of the Commission, for good cause shown, may grant an extension of a data submission date.

.03 Freestanding Medical Facility Pilot Project.

The freestanding medical facility pilot project shall report data to the Commission as specified under Regulation .02 of this chapter.

.04 Summary Studies, Reports, and Compilations.

A. Subject to §B of this regulation, summary studies, reports, or other compilations developed by the Commission from the data submitted in accordance with this chapter are public information.

B. Disclosure under §A of this regulation may not be made in such a way that the data furnished for a specific patient can be identified.

Other Relevant Data Bases

Financial Data Base

The Health Services Cost Review Commission maintains a Financial Data Base that collects aggregate monthly data on gross revenue and volume of service by revenue center. The information in this financial data base includes emergency department visits discharged and emergency department visits admitted. Because this aggregate level data base has been in place for some time, it is used to analyze trends over time in Maryland hospital emergency department visits.

Maryland Hospital Outpatient Data Base

The Maryland Hospital Outpatient Data Base collects patient-level data on outpatient services, including discharged emergency department visits. Data elements reported include: patient demographic characteristics (e.g., age, sex, race, zip code/county of residence), expected payment sources, diagnosis and procedure codes, and charges. This data base is used to compare the characteristics of patients using hospital-based emergency department services that are discharged without being admitted for inpatient care with the freestanding medical facility pilot project.

This newer data base, which is also maintained by the Health Services Cost Review Commission, was revised to provide a single format for collecting data on all outpatient services

including the emergency department as well as ambulatory surgery, labor/delivery, and clinic services. Prior to these changes, there were separate data bases for ambulatory care services, including emergency department encounters, and outpatient surgery services. Changes to the Outpatient Data Base altered the criteria for selecting emergency department cases and resulted in differences in visit volumes when comparing emergency department services between this data base and the Financial Data Base.

Maryland Hospital Inpatient Data Base

The Maryland Hospital Inpatient Data Base, which is collected by the Health Services Cost Review Commission, reports patient-level data on all hospital inpatients. Like the Hospital Outpatient Data Base, data elements reported include: patient demographic characteristics (e.g., age, sex, race, zip code/county of residence), expected payment sources, diagnosis and procedure codes, and charges. The Hospital Inpatient Data Base includes a data element that identifies patients admitted from the emergency department. To obtain data on the characteristics of total emergency department visits, it is necessary to combine data collected for discharged emergency department visits from the Hospital Outpatient Data Base with admitted emergency department visits from the Hospital Inpatient Data Base.

For this study, patients admitted for inpatient care at Shady Grove Medical Center following treatment at the Germantown Emergency Center were identified by a revenue code in the Hospital Inpatient Data Base assigned by Adventist HealthCare, Inc.

Appendix 6

Emergency Department Services: Evaluation and Management Services Coding

Emergency Department Services: Evaluation and Management Services Coding 99281:
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor 99282:

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. 99283:

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. 99284:

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- A detailed history;
- A detailed examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

99285:

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and pose an immediate significant threat to life or physiologic function.

99291 Critical Care, Evaluation and Management of the critically ill or critically injured patient, first 30-74 minutes.

Source: Current Procedural Terminology, CPT 2015, CodeManager Online Professional, Emergency Department Services. American Medical Association, <https://ocm.ama-assn.org/OCM/codemanager/CPT.do>