IN THE MATTER OF	*	BEFORE THE
	*	
WASHINGTON ADVENTIST HOSPITAL, INC.	*	MARYLAND HEALTH
	*	
Docket No. 13-15-2349	*	CARE COMMISSION
	*	

* * * * * * * * * * * * *

HOLY CROSS HOSPITAL OF SILVER SPRING'S EXCEPTIONS TO RECOMMENDED DECISION APPROVING THE MODIFIED CON APPLICATION PROPOSING THE REPLACEMENT OF WASHINGTON ADVENTIST HOSPITAL

Holy Cross Hospital of Silver Spring, Inc. ("HCH")[1], by its undersigned counsel and pursuant to COMAR §10.24.01.09B, submits these exceptions to Commissioner Phillips' recommended decision proposing approval, with conditions, of the Modified Certificate of Need Application filed by Adventist HealthCare, Inc. ("AHC") d/b/a Washington Adventist Hospital ("WAH") (the "Recommended Decision"). As explained below, HCH respectfully requests that the Maryland Health Care Commission modify the Recommended Decision to require AHC to provide meaningful and needed emergency services for the Takoma Park community in the form of a freestanding medical facility ("FMF").

INTRODUCTION

HCH submits these exceptions to the Recommended Decision in an effort to ensure that the diverse population WAH currently serves will continue to have access to the appropriate

[1] HCH is part of Holy Cross Health, a Maryland-based health system. Through a combination of innovation, alignment, partnership, fundraising, and a steadfast stewardship of the resources entrusted to it, Holy Cross Health is a leading provider of community benefit, providing more than $56 million in community benefit in 2014, including an all-time high of $30 million in free or reduced-cost services to those facing financial barriers to care. Holy Cross Health partners with the community on many outreach activities to support improving the health of the individuals it is privileged to serve. HCH has been a steward of the health of its diverse community located in Silver Spring, Maryland, and the surrounding service area for more than 50 years.

level of health care services on WAH's existing Takoma Park campus, and to prevent an undue burden on HCH's own ability to meet the health care needs of its service area population. Specifically, HCH requests that the Commission condition approval of the relocation of WAH on the establishment of an FMF to serve the emergency services needs of the residents of WAH's existing primary service area, and avoid diminished access to behavioral health services.[2]

The Reviewer, like HCH, is rightfully concerned about the adverse effects relocation would have on the residents of WAH's existing primary service area. *See* Recommended Decision ("R.D.") at 22, 38. While the Recommended Decision proposes a condition requiring the provision of urgent care services in Takoma Park, HCH believes that it is too risky for the Commission to allow AHC to eliminate all inpatient services and emergency services.[3] To

---

[2] Throughout this CON review HCH has opposed AHC's proposed relocation project on several grounds, but most central to HCH's objections are its concerns about the adverse impact the relocation would have on both WAH's existing primary service area and HCH's ED services. At this point, HCH is adopting the focused approach of asking the Commission to condition approval of the proposed project on the establishment of an FMF, rather than asking the Commission to deny approval of the proposed project altogether.

[3] As discussed herein, an FMF will provide a more effective point of intake for behavioral health admissions than an urgent care center. Also, unless rectified, the State's current lack of a waiver from the Medicaid Institutions for Mental Diseases ("IMD") exclusion will produce more difficulty for adult Medicaid patients in need of admission to the new AHC specialty psychiatric hospital that will be established if the proposed project is approved. The transformation of the existing behavioral health unit at WAH into a new stand-alone specialty hospital, as proposed, will cause the new facility to be restricted by the Medicaid IMD exclusion. In connection with the loss of the IMD Waiver, the Department of Health and Mental Hygiene ("DHMH") issued a letter to providers explaining that, in light of the loss of the IMD waiver, emergency departments must make an effort to admit all adults presenting in an ED in need of behavioral care into an acute care general hospital and to use the Maryland Bed Registry to find the nearest acute care general hospital with open psychiatric beds. For adult Medicaid patients, "[i]f the ED is unsuccessful in admitting the patient to its own or another acute care general hospital's psychiatric beds using the Bed Registry, the ED must call no less than four (4) acute care general hospitals to find an open psychiatric bed prior to requesting authorization from VO for admission to an IMD." A copy of the DHMH letter is attached as **Exhibit 1**. Medicaid admissions to WAH's existing behavioral health unit are not affected by the IMD exclusion because the unit is part of an acute general hospital.

address the adverse effects of WAH's relocation, HCH urges the Commission to require a higher level of emergency care in Takoma Park as a condition of approval.

As explained more fully below, without conditioning the relocation of WAH on the opening of an FMF on the Takoma Park campus, the relocation will adversely impact the residents of WAH's overall service area, adding undue duress to individuals in its long-standing emergency department ("ED") service area, especially those who experience greater socio-economic barriers in accessing care, many of whom are uninsured, such as low income individuals, and less mobile individuals and families. Also, without an FMF in Takoma Park, AHC's proposal will unduly burden the other hospitals in WAH's current ED service area. HCH's ED already operates at near capacity. Contrary to the findings in the Recommended Decision, the relocation of WAH will increase demand for care at HCH's ED, especially among patients whose needs also require additional resource support after receiving care in the ED. The mere opening of an urgent care center will neither significantly relieve ED volume nor provide all of the services needed in the Takoma Park area.

ARGUMENT

I. THE RECOMMENDED DECISION ERRONEOUSLY FINDS THAT RELOCATING WAH FROM TAKOMA PARK TO WHITE OAK WILL NOT HAVE AN "ADVERSE IMPACT" ON ACCESS TO SERVICES, INCLUDING ACCESS FOR THE INDIGENT AND/OR UNINSURED.

Standard .04B(4)(b) provides that a project that "reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access to the indigent and/or uninsured." Although the Reviewer expressed concern about the impact the

relocation of WAH will have on the population in the existing primary service area, the Recommended Decision finds that the project is consistent with Standard .04B(4)(b), in part, because the Recommended Decision would require AHC to establish urgent care services on the Takoma Park campus, which will be available following the relocation of WAH. R.D. at 38 ("However, since AHC's representations regarding its commitment to this [urgent care center] are such an important part of [finding consistency with Standard .04B(4)(b)], I am recommending that the Commission attach a condition related to this standard if it approves this project."). That is, the Reviewer's finding of consistency with Standard .04B(4)(b) depends upon the requirement that AHC continue to provide services that will replace some of the existing ED capacity in Takoma Park.

Also, the Reviewer conducted her own independent analysis to determine whether the travel time to a hospital ED would be inappropriately compromised by the relocation of WAH. R.D. at 36-37. The Reviewer's analysis involved a study of the 52 census block-groups ("CBGs") that were most dependent on the WAH ED in 2014 (*i.e.*, those CBGs sending ≥ 50% of total ED visits to WAH). Based upon the analysis of relative drive times from these 52 CBGs to a hospital ED, before and after the proposed relocation, the Reviewer determined that the relocation will not inappropriately diminish accessibility for the population living in the CBGs. Appendix 4 to the Recommended Decision contains a compilation of the data supporting the Reviewer's findings.

In fact, the Reviewer's analysis confirms the validity of HCH's concerns about accessibility to emergency services and the impact of WAH's relocation on HCH's ED. A review of the data in Appendix 4 shows that following the relocation of WAH, the drive time from <u>all</u> 52 CBGs will be shorter to HCH than to the relocation site in White Oak. In 50 of the

52 CBGs, HCH is the next closest hospital; thus, most of the people living within these 50 CBGs, where 26,467 ED visits originated in 2014, will use HCH's ED after relocation. As noted by the Reviewer: "[a]ll 52 CBGs were a shorter drive time to the existing WAH than to [HCH]. All will be closer to HCH than to WAH if WAH moves to White Oak." R.D. at 37. The data compilation in Appendix 4 shows that average drive times to the closest hospital ED will more than double for the people living in the 52 CBGs after the relocation of WAH.[4]

The Reviewer also acknowledged that the median household income in 25 of the 52 CBGs was below 85% of the 2013 Maryland median household income. Id. Indeed, the median household income exceeded the Maryland median household income (according to 2013 census data) in only 10 of the 52 CBGs. As discussed in the initial written comments submitted by MedStar Montgomery Medical Center, the areas for which WAH is currently the closest hospital have a poverty rate of 30% and a severe poverty rate of 12.2%. MedStar Comments (DI #52) at 16. In sum, the people who depend most heavily on WAH's ED services are underprivileged. The Reviewer's analysis demonstrates that the relocation of WAH will leave this population with diminished access to emergency services, substantially increasing drive times to the closest hospital ED. Permitting AHC to make emergency services more distant and less accessible for this population should not be regarded as consistent with Standard .04B(4)(b) without a meaningful alternative to WAH's existing ED.

An urgent care center is inadequate to serve this population, as discussed in Section III.B, below. Moreover, as discussed in Section II, below, the option of a more distant hospital ED at

---

[4] According to the data for the 52 CBGs, the cumulative average of the drive times to WAH in Takoma Park is 3.33 minutes. The cumulative average of the drive times to HCH, the next closest hospital in almost every CBG, is 8.39 minutes.

HCH for the people who most depend on WAH's ED is not a viable alternative because the relocation will cause the HCH ED to be overburdened.

II. AHC'S PROPOSAL TO BUILD A REPLACEMENT HOSPITAL IN WHITE OAK IS NOT CONSISTENT WITH REVIEW CRITERION .08G(3)(F), DUE TO THE UNTOWARD IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM.

Review Criterion .08G(3)(f) requires an applicant to assess the impact of a proposed project on existing providers and the health care delivery system. The relocation of WAH will have an untoward impact on HCH's ED by substantially increasing the volume of ED visits at HCH. HCH demonstrated this impact by submitting a zip code market share analysis, showing the likely ED market shifts that will occur if AHC is permitted to relocate WAH without replacing its ED capacity on the existing Takoma Park campus.

A. HCH Projects Substantial Increases in ED Visits as a Result of the Proposed WAH Relocation.

HCH expects that the proposed relocation of WAH would increase HCH's ED volume and result in insufficient access for patients, particularly those with the greatest need for emergency care (*see* Section I, *supra*). HCH recently rebuilt and expanded its ED and has no space to expand on its current site. The most recent expansion of the hospital's footprint required a zoning variance and consumed essentially all buildable space on the HCH campus, which is land locked by a park, a residential neighborhood, and the Washington Beltway (I-495). Currently, HCH operates its ED at near capacity overall and frequently faces challenging peak demands. ED capacity is driven by a number of factors, including bed availability in the acute or intensive care inpatient areas, acuity of patients in the ED, surge times of day, and types of patients being seen in the ED.

HCH's analysis projects that, if the Commission approves the relocation of WAH, the HCH ED would receive a significant increase in ED volume as a result of the market shift. As applied to CY 2014 experience,[5] the relocation likely would result in a total shift of 13,302 additional ED cases to HCH, or a 15% increase of its three-year ED case average of 88,000 cases, a shift that would bring its yearly volume of ED cases to more than 100,000. A complete set of tables showing HCH's projections of ED market shift, source data, and a summary of HCH's methodology, are attached collectively as **Exhibit 2**.

B. The Alternative ED Market Share Analysis in the Recommended Decision Does Not Accurately Account for HCH's Market Share After the Relocation of WAH.

In response to HCH's demonstration that the relocation of WAH's ED would substantially increase ED visits at HCH, AHC criticized HCH's analysis, but presented no alternative analysis, despite bearing the burden of assessing the impact of a proposed project on existing providers and the health care delivery system under Review Criterion .08G(3)(f).

The Reviewer did perform an ED services market share impact analysis (*see* R.D. at 161-63), which purports to refute HCH's analysis. However, the Recommended Decision does not include the full analysis. The Recommended Decision merely describes the methodology of the analysis, includes a summary table for 12 zip codes (Table IV-60),[6] and does not include any backup material showing the detailed calculations supporting the analysis. Furthermore, for the reasons discussed below, the Reviewer's analysis underestimates the likely number of ED visits that would be diverted to HCH in the existing WAH primary service area ("PSA") and

---

5 Based on nine month CY 2014 data, as supplied to the HSCRC, annualized.

6 HCH analyzed the 31 zip codes AHC identified as its total service area. Appl. at 54-55.

overestimates the likely number of ED visits that the relocated WAH would draw from HCH's existing PSA.

First, the methodology used in the Recommended Decision does not sufficiently account for the effect of established patterns of ED use, which are driven by habitual practice, loyalty and other factors. The residents living in the existing WAH PSA will be "forced" to change their established patterns of ED use because their ED of choice will be eliminated upon the relocation of WAH. That is, they will have to choose whether to begin visiting the next closest hospital ED (HCH) or travel a longer distance to the relocated WAH. However, residents who currently use HCH's ED will not be "forced" to do anything different – their ED of choice (HCH) will remain in the same location, providing the same services. While some of these people will choose to begin using the ED at the relocated WAH, many simply will continue their established pattern of ED use at HCH, especially in light of HCH's overall excellent reputation, payer relationships, and patient loyalty.[7] HCH's analysis accounts for HCH's strong market shares in some of the zip codes that are closer to WAH's proposed relocation site in White Oak.

Second, the ED market share analysis in the Recommended Decision used zip code level data, although the Commission has access to ED visit data at the much smaller CBG level.[8]

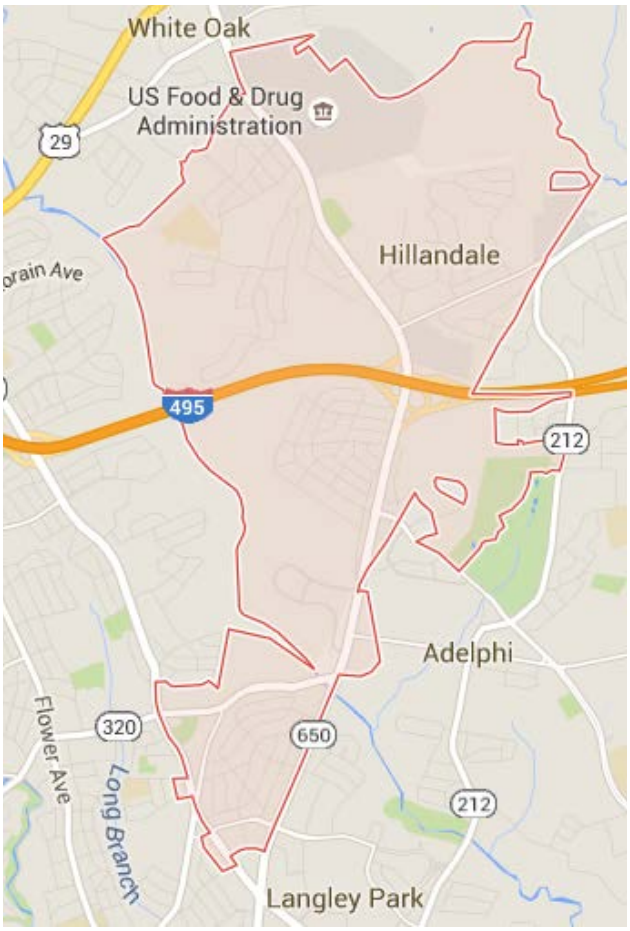
---

[7] For example, according to the US News and World Report rankings of hospitals, HCH currently is ranked as the ninth best hospital in Maryland and the top ranked hospital in Montgomery County. Also, many people use the HCH ED because their insurance provider chooses HCH over other hospitals as a high-quality, low-cost partner. For example, Kaiser Permanente has selected HCH as one of only five Maryland hospitals as a "premier hospital" based on an evaluation of quality of care, comfort, and patient service. *See* http://premierhospitals.kaiserpermanente.org/premier-hospitals-in-mdvadc/holy-cross-hospital/. As a result, Kaiser places 74% of its inpatient admissions in the area at HCH. Similarly, CareFirst BlueCross BlueShield selected HCH as a "partner in care."

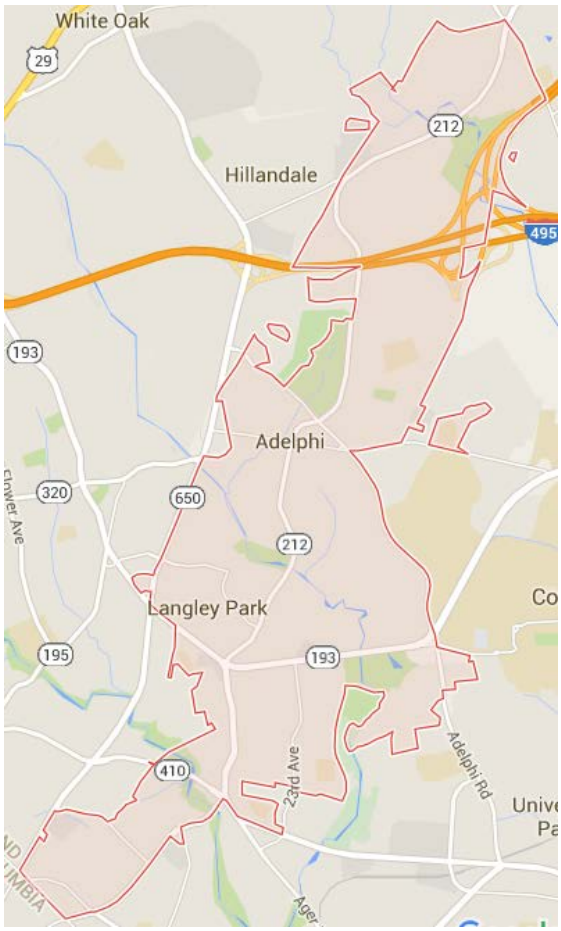
[8] HCH does not have access to CBG level ED data. Otherwise, it would have used this data in preparing its impact analysis.

Indeed, in determining whether the proposed project is consistent with the adverse impact standard (Standard .04B(4)(b)), the Reviewer used CBG level ED visit data to assess impact on the Takoma Park community. R.D. at 36-38; Appendix 4. There, the Reviewer stated: "I was receptive to the suggestion that analysis at a zip code level might obscure this impact given the size and diversity of zip code populations." R.D. at 36. Similarly, analyzing the impact of ED visits on other providers, such as HCH, also is obscured at a zip code level.

For example, zip code 20903 (depicted below) is almost 3.5 miles from the northernmost boundary to the southernmost boundary. Many of the people living in the southern portion of this zip code are closer by drive time to HCH than to the proposed relocation site for WAH. Also, a significant portion of the northern area of the zip code (that closest to WAH's proposed location at White Oak) is comprised of non-residential land occupied by the campus of the U.S. Food and Drug Administration and the U.S. Army Research Laboratory. Yet, the Reviewer's analysis assumes substantial shift to WAH based on zip code level proximity. Likewise, zip code 20783 (also depicted below) is six miles long from the boundary in the southwest on the District of Columbia line to the northeast boundary in Beltsville, Maryland. Depending upon where they live in the zip code, some people are closer to HCH and others are closer to WAH's proposed relocation site. To perform a more accurate ED visit market share analysis, the Commission should analyze CBG level data, as the Reviewer did for purposes of assessing consistency with Standard .04B(4)(b).



Zip Code 20903



Zip Code 20783

III. THE PROPOSED PROJECT SHOULD NOT BE APPROVED WITHOUT A CONDITION THAT AHC ESTABLISH A FREE STANDING EMERGENCY MEDICAL CENTER IN TAKOMA PARK.

AHC proposes to renovate the Takoma Park campus to include, among other services, a Federally Qualified Health Center ("FQHC") operated by Community Clinic, Inc., and the existing Women's Center, providing prenatal and other services for the community, including low-income women, and a new walk in primary care clinic. Modified Application ("Appl.") at 25. AHC contends that these services in Takoma Park will "meet the needs of the community." Appl., Ex. 6. AHC states that these services are not a "formal element" of its

application, and these promised services would not remedy the significant adverse impact of the relocation of WAH.

Out of concern for the adverse impact of relocation on WAH's existing PSA, the Reviewer recommended the following condition for approval of the project:

> Adventist Health Care must open an urgent care center on its Takoma Park campus coinciding with its closure of general hospital operations on that campus. The urgent care center must be open every day of the year, and be open 24 hours a day. Adventist Health Care may not eliminate this urgent care center or reduce its hours of operation without the approval of the Maryland Health Care Commission.

R.D. at 38. While HCH agrees that AHC should be required to provide additional services on the Takoma Park campus as a condition of approval of the relocation of WAH, the Commission should require an FMF, not an urgent care center.

A. FMFs in Maryland.

Pursuant to a legislative requirement, the Commission provided a Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities (the "Commission's FMF Report"), dated February 4, 2015. Among other things, the Commission's FMF Report notes that "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." While Maryland ED visits declined in 2014, the annual increases in volume for almost 20 years did not abate while urgent care centers proliferated throughout the State and the nation.[9] In 2014, the American College of Emergency Physicians (ACEP) concluded that Maryland's EDs remain overcrowded with one of the longest median wait times (367 minutes from ED arrival to departure for

[9] As noted in the Commission's FMF Report, there are approximately 10,000 urgent care centers in the United States, and urgent care is one of the fastest growing health care fields. Commission's FMF Report at 8, citing Urgent Care Ass'n of America.

admitted patients). *See* http://www.emreportcard.org/uploadedFiles/States/Maryland/Maryland.pdf. ACEP also reported that Maryland has too few EDs per capital (8.3 per 1 million people). Id. ACEP recommended that Maryland "support efforts to increase capacity for emergency care and alleviate crowding in EDs." *Id.* This is a particularly significant problem in Montgomery County, which has 25.18 ED treatment spaces per 100,000 residents, fewer treatment spaces per capita than other Maryland regions and well below the statewide rate of 35.44 spaces per 100,000 residents. *See* MONTGOMERY COUNTY OFFICE OF LEGISLATIVE OVERSIGHT, Behavioral Health in Montgomery County (July 28, 2015) ("OLO Report) at pp. 105-107 (http://www.montgomerycountymd.gov/OLO/Resources/Files/2015_Reports/OLO%20Report%202015-13%20Behavioral%20Health%20in%20Montgomery%20County.pdf).

As discussed in the Commission's FMF Report, one approach for alleviating crowding of EDs is to establish FMFs as satellites of existing acute general hospitals. Presently, three FMFs operate in Maryland under a statutory pilot program: (1) the Germantown Emergency Center (operated by an affiliate of AHC); (2) Queen Anne's Emergency Center (operated by an affiliate of the University of Maryland Medical System); and (3) the Bowie Health Center (operated by Dimensions Health System). Until July 1, 2015, there was a moratorium on the establishment of new FMFs in Maryland. MD. CODE ANN., HEALTH-GEN. § 19-3A-03(a)(2) (2014). The Commission is now preparing for the establishment of new FMFs in the State. A Commission workgroup has been meeting since August of this year to discuss and comment on a draft chapter of the State Health Plan for FMFs. *See* http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/freestanding_med_facility/chcf_fmf_workgroup_draft_discussion_20150828.pdf. Also, the Commission has scheduled September 9, 2016 as the submission date

for CON applications for the establishment or relocation of an FMF. MARYLAND REGISTER, Volume 42, Issue 22, p. 1417 (October 30, 2015).

B. Takoma Park Needs an FMF, Not an Urgent Care Center.

As discussed in Sections I and II, *supra*, the elimination of emergency services in Takoma Park would have an inappropriate adverse impact on WAH's existing PSA population, especially within the City of Takoma Park, and it likely would cause the already busy HCH ED to become overburdened with ED visits. The required establishment of an urgent care center, as recommended by the Reviewer, will not provide enough needed services for the PSA population and it will not sufficiently relieve the burden on HCH's ED.

In general, an urgent care center is a location where unscheduled outpatient low acuity treatment is provided. Unlike FMFs, urgent care centers are largely unregulated and undefined. According to a survey by HCH, there are already about 40 urgent care centers in Montgomery County alone, and approximately 25% of these have opened since 2012 (a list of Montgomery County urgent care centers is attached as **Exhibit 3**). The opening of these urgent care centers has not significantly reduced ED volumes in the County.

There are several significant advantages to requiring AHC to establish an FMF in Takoma Park, rather than an urgent care center. First, FMFs are able to handle higher acuity injuries and illnesses. As admitted by AHC, an urgent care center on the Takoma Park campus would be able to treat less than half of the ED visits that occurred in WAH's ED in 2014. R.D. at 33. For purposes of assessing impact on the residents in WAH's existing PSA, the Reviewer assumed that only about 25% of the WAH ED visits could be handled by an urgent care center. R.D. at 38. While an urgent care center may be able to absorb some of the ambulatory-care sensitive patient needs, it would be unable to address emergent medical needs.

Second, unlike primary care or even urgent care clinics, FMFs have emergency treatment services and are able to accept patients arriving via 911 ambulance service, and are able to provide care for conditions that exceed the care the staff and equipment of a primary care center can accommodate. Of particular significance here, emergency care providers are better equipped to manage patients with behavioral health conditions. Between 2010 and 2013, mental health visits in Montgomery County increased by 38%. OLO Report, *supra*, at 106. No urgent care center in the County accepts patients with behavioral or mental health conditions for treatment. It is unreasonable to assume that residents would believe an urgent care center on the Takoma Park campus would be any different, especially since the existing urgent care centers operated by Centra Care, an affiliate of AHC, are among the centers that do not accept mental health patients for treatment or triage.

Third, the establishment of an FMF would ensure both enforcement ability by the Commission and access for the uninsured and underinsured. COMAR § 10.07.08.09 provides that "[r]egardless 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." FMFs are also subject to the Emergency Medical Treatment and Active Labor Act (EMTALA), which prohibits discrimination based on a patient's ability to pay. Moreover, FMFs are subject to licensure requirements. *See* COMAR § 10.07.08.04. As stated in the Commission's FMF Report, unless they are affiliated with a hospital, urgent care centers "may not accept all types of insurance and may require full payment at the time of service, if the

patient lacks insurance."[10] Commission's FMF Report at 8. Indeed, a recent survey by HCH of a select group of Montgomery County urgent care centers revealed that these centers require some form of payment upon seeing a patient.

Fourth, the establishment of an urgent care center in the existing ED at WAH would merely duplicate existing services already available to people residing in WAH's PSA. As noted, Montgomery County already has some 40 urgent care centers. More importantly, it is not clear how the services offered in a new urgent care center would differ from those provided on the same Takoma Park campus in the existing FQHC, which, according to AHC, will expand.

Finally, for a number of reasons, an FMF is particularly well suited for AHC's Takoma Park campus:

- The establishment of the FMF would require relatively little capital expenditure since it will be established on the site of an existing ED. Presumably, the cost would not exceed the cost of renovating the same space for an urgent care center. Also, since the Recommended Decision would require 24/7 services any way, there will not be significantly increased staffing costs to operate a FMF rather than an urgent care center.
- Because AHC states that it intends to maintain laboratory, pharmacy, and radiology in the current configuration in the building (Appl. Ex. 6), there will not be any additional cost to comply with the FMF regulatory requirements to maintain these same services. *See* COMAR § 10.07.08.12, *et seq*.

---

[10] It is not clear whether EMTALA would apply to an urgent care center established by AHC on the Takoma Park campus. This question would require a fact-based analysis under the EMTALA regulations after AHC structures the ownership and operation of the proposed urgent care center. The law is clear with respect to FMFs – EMTALA applies to these facilities.

- Since an FMF in Takoma Park could receive EMS transports, it would serve as an appropriate and efficient intake and assessment point for behavioral health patients who are in need of admission into AHC's onsite specialty psychiatric hospital. Without an FMF, certain behavioral health patients may need to be transported to a hospital ED elsewhere for assessment and then transported back for admission in Takoma Park.

In short, it would be difficult to identify a more cost effective location to establish an FMF than the existing ED at WAH.

C. Proposed Modified Condition to Establish an FMF.

For the reasons discussed above, HCH urges the Commission not to approve the relocation of WAH without requiring AHC to establish an FMF on its Takoma Park campus. HCH recognizes that existing law would require AHC to obtain a CON to establish the FMF. Accordingly, HCH proposes the following modified condition of approval:

> Adventist Health Care must obtain approval for, and open, a freestanding medical facility ("FMF") on its Takoma Park campus coinciding with its closure of general hospital operations on that campus. The FMF must be open every day of the year, and be open 24 hours a day. Adventist Health Care may not eliminate this FMF or reduce its hours of operation without the approval of the Maryland Health Care Commission.

CONCLUSION

AHC's application should not be approved without a condition that it establish an FMF because AHC: (1) failed to demonstrate that relocating will not diminish access to ED care for uninsured and Medicaid patients in WAH's current service area, as required by Standard .04B(4)(b); and (2) failed to show no untoward impact on existing providers and the health care system, as required by Review Criterion .08G(3)(f).

For the reasons set forth above, HCH respectfully asks that the Commission deny AHC's Modified Application proposing to replace WAH with a new hospital in White Oak unless AHC establishes an FMF in Takoma Park.

Respectfully submitted,

Thomas C. Dame
Ella R. Aiken
Gallagher Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore MD 21201
(410) 727-7702

Attorneys for Holy Cross Hospital of Silver Spring, Inc.

December 2, 2015

EXHIBITS

1 DHMH letter to providers regarding IMD exclusion (August 24, 2015)

2 HCH's projections of ED market shift, source data, and methodology summary

3 Montgomery County urgent care centers

CERTIFICATE OF SERVICE

I hereby certify that on the 2nd day of December 2015, a copy of the foregoing

Exceptions of Holy Cross Hospital of Silver Spring was sent via email and first-class mail to:

John F. Morkan III, Esq.
Howard L. Sollins, Esq.
John J. Eller, Esq.
Ober, Kaler, Grimes & Shriver
120 East Baltimore Street
Baltimore MD 21202

Kurt J. Fischer, Esq.
Marta D. Harting, Esq.
Venable LLP
750 East Pratt Street, Suite 900
Baltimore MD 21202

Susan C. Silber, Esq.
Silber, Perlman, Sigman & Tilev, P.A.
7000 Carroll Avenue, Suite 200
Takoma Park MD 20912-4437

Suellen Wideman, Esq.
Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215-2299

Ms. Catherine S. Tunis
SOSCA President
907 Larch Avenue
Takoma Park MD 20912

Thomas C. Dame

I hereby declare and affirm under the penalties of perjury that the facts stated in Holy Cross Hospital of Silver Spring's Exceptions to Recommended Decision Approving the Modified CON Application Proposing the Replacement of Washington Adventist Hospital and its attachments are true and correct to the best of my knowledge, information, and belief.

December 2, 2015
Date

Kristin H. Feliciano
Chief Strategy Officer
Holy Cross Hospital

#519942
009849-0029

EXHIBIT 1

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

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

August 24, 2015

Dear Colleague:

We are writing to bring to your attention recent changes to the Department of Health and Mental Hygiene's (the Department) process for admitting adult psychiatric patients to Institutions for Mental Diseases (IMDs) within the Public Behavioral Health System.

For the past three years, the Department has participated in a Medicaid Emergency Psychiatric Demonstration that made Medicaid funds available to private free standing psychiatric hospitals (IMDs) for emergency inpatient psychiatric care provided to Medicaid enrollees aged 21 to 64.[1] These IMDs include, but are not limited to, Sheppard Pratt, Adventist Behavioral Health, and Brook Lane.

This three-year federal demonstration ended on June 30, 2015, and effective July 1, 2015, all adult psychiatric admissions to IMDs must now be paid with state general funds only. The state general funds budgeted for adult admissions to IMDs is significantly lower than the cost projected for fiscal year 2016. Therefore, for all adults presenting to an acute care general hospital Emergency Department (ED), in need of an inpatient psychiatry admission, every effort will be made to admit the individual to an Acute Care General Hospital. To accomplish this, all acute care general hospitals will be instructed to participate in and use the Maryland Psychiatric Bed Registry. All EDs will need to use the Bed Registry to find the nearest acute care general hospitals with an open psychiatric bed and coordinate the admission with the receiving hospital and VO. Please advise your admissions department to work collaboratively with acute care general hospitals and VO to divert Medicaid admissions to any open acute care general hospital psychiatry unit bed, whenever possible.

If the ED is unsuccessful in admitting the patient to their own or another acute care general hospital using the Bed Registry, the ED must call no less than four (4) acute care general hospitals to find an open psychiatric bed prior to requesting authorization from VO for admission to an IMD. If these calls have not been completed, VO will instruct the ED to attempt to admit the patient to an acute care general hospital by making these calls before it will authorize admission to an IMD. Ultimately, admissions to IMDs will be considered as a last resort in situations where no community hospital psychiatric bed is available and emergency psychiatric inpatient treatment is indicated.

We understand that this change is difficult for these organizations. Please note that the Department is seeking a federal waiver from the IMD Exclusion. If approved by the Centers for Medicare and Medicaid Services (CMS), Maryland would have the ability to reimburse IMDS for the treatment of Medicaid enrollees aged 21-64 with acute psychiatric and substance-use-related needs and would receive federal

[1] The Medicaid Emergency Psychiatric Demonstration was established under Section 2707 of the Affordable Care Act. The District of Columbia and 11 states, including Maryland were selected to participate in the Demonstration.

matching dollars. A copy of the waiver application and supporting documentation can be accessed at: http://dhmh.maryland.gov/SitePages/IMD%20Exclusion%20Waiver.aspx

Moreover, CMS is seeking public comment on Maryland's waiver application until September 11, 2015. We encourage you to submit comments here: https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1878723

Should you have any questions or concerns regarding this policy, please contact Dr. Zereana Jess-Huff, CEO to ValueOptions, Inc., Maryland by dialing 410-691-4000 or Zereana.jess-huff@valueoptions.com.

Sincerely,

Gayle Jordan-Randolph, M.D.
Deputy Secretary
Behavioral Health

Shannon McMahon
Deputy Secretary
Health Care Financing

EXHIBIT 2

Summary of HCH ED Services Impact Analysis Methodology

A. Summary of Impact Analysis.

In forecasting the potential transition of ED visits from WAH to HCH and other hospitals in the region, HCH considered multiple factors and utilized data that was provided by WAH, available through the HSCRC databases, or common sources. In making projections related to WAH's current ED's primary service area ("PSA") patient load, HCH took into account drive time and ED market share as of September 30, 2014 (as provided by the HSCRC). To validate, HCH also reviewed area trends and referral patterns available through Advisory Board Crimson Market Advantage.

HCH's analysis included a range of possible outcomes. In each one, ED volume shifted to HCH and the other hospitals in the area, in particular Laurel Regional Hospital, Prince George's Hospital Center, and Doctors Community Hospital.

HCH is provided the Commission staff with a Microsoft Excel file showing HCH's methodology and source references for the ED volume shift projections. A PDF version of the spreadsheet is attached. In the spreadsheet, HCH annualized the first nine months of CY 2014 ED volumes for the total market, arranged by zip code and then allocated by current market share for each zip code. If census block group data for ED visits were available, HCH would have used this data to develop a more precise and accurate impact analysis.

HCH used WAH's projection of MSGA market shift and applied this projection to the ED volume analysis. This provided a low end to the HCH projections, as that analysis assumes dramatic shifts to WAH's new ED that are not likely. For example, WAH's projected MSGA shift, as applied to WAH's ED shift, would assume that WAH would increase its market share in zip code 20904 from a current ED market share of 11% to a market share of 57%. This is not only unlikely, it is implausible, given that the drive time difference to the zip code's market leader, HCH, is only an average of four minutes longer than to the site of the proposed relocated WAH, and in some areas of the zip code, the residents would remain closer to HCH than WAH's proposed relocation site.

B. Description of Impact Analysis Spreadsheet and Calculations

For orientation to the impact analysis and the HCH methodology, please refer to the attached spreadsheet. The 31 zip codes for WAH's existing total service area ("TSA") are listed. The top eight zip codes, highlighted in yellow, are the zip codes included in the WAH ED primary service area ("PSA"), as defined by AHC. *See* Modified Application at p. 54-55. The remaining zip codes represent the secondary service area ("SSA") for the existing campus. As reflected on the map on page 56 of the Modified Application, HCH is the only other hospital located within the PSA for the WAH Takoma Park ED. Also, as shown on page 57 of the Modified Application, HCH is the only hospital located in the PSA for the proposed new location of WAH in White Oak.

The column labeled "Total Market ED Visits" represents nine months of CY 2014 data, then annualized in the next column, of ED visit volume per zip code as provided by the HSCRC quarterly reporting. The next several columns show the top three hospitals by market share of ED visit volume for each of the 31 zip codes. If WAH was not in the top three, HCH indicated

WAH's market share in the next columns. The column labeled "WAH volumes based on Current Share Annualized" shows WAH's volume in each zip code. This was derived by multiplying the percentage share of WAH by the annualized total market ED visits.

The next column in the spreadsheet is labeled "WAH MSGA Share Point Shift." AHC did not calculate the expected market share shifts for WAH's ED visit volume. Thus, HCH used AHC's projection of WAH's MSGA volume shift (*see* Modified Application at p. 105) as a proxy for AHC's analysis. As explained in the Modified Application, WAH calculated market share shift based on drive times, current market leaders, and physician relationships in each zip code in the WAH MSGA TSA. With this calculation, WAH redefined its MSGA TSA, with four zip codes dropping out of its PSA and ten dropping out of its TSA. Modified Application, p. 106. Since HCH was unable to ascertain the methodology behind each of these calculations, and AHC did not make calculations specific to ED volume, HCH used AHC's assessment of WAH's MSGA market share shift to extrapolate the impact on ED volumes.

Since ED volumes respond similarly to MSGA shift, but not entirely the same, HCH considered drive times, ED utilization trends for emergent diagnosis, and existing market share disposition to calculate a revised market share shift. The next series of columns show the calculation of ED volume shift based on the WAH MSGA shift projections. Next, in the columns under the heading "HCH Projections after WAH Relocation," HCH shows its prediction of the ED share shift would be for each zip code. This represents total market share shift of WAH's ED volumes involving all area hospitals. The distribution of these patients likely will follow the same pattern as the existing market share distribution for hospitals outside of WAH. Therefore, the column labeled "Annual volume shift toward / (away) HCH," shows only the ED visit volume shift that is projected to go to (or from) HCH. This shift was determined by assuming the relocated WAH at White Oak would achieve the ED volume market share identified in the column labeled "WAH proposed new share after move," and the remaining ED volume market share was allocated proportionately among the hospitals identified as the other top hospital providers in the spreadsheet.

In WAH's existing ED PSA, HCH is the top provider of ED services in four of the eight zip codes, with significant market shares of between 49.5% and 65.60%. In three of the eight zip codes, HCH is second in total market share percentage. In each of those zip codes (20783, 20912, and 20782) WAH currently has the leading market share by a significant margin (between 53% and 60%) with HCH having between 18% and 25% market share. In the last of the PSA eight zip codes, Doctors Community Hospital, WAH, and HCH have roughly equivalent market share.

<u>Zip Codes 20783, 20912, 20782, 20903, and 20901</u>: In forecasting ED volume shift, HCH projected that in these five zip codes WAH will experience a 95% market share shift away from WAH to the other top providers in the region. Four of these zip codes have faster drive times to HCH than to WAH. HCH has between 25-65% share already and is either the market leader or the second place hospital. In the fifth zip code, 20903, the hospitals are nearly equidistant in drive time, HCH is the market leader, and much of the population in that zip code is located in the southern portion of the zip code, closer to HCH (the northern portion, closest to the proposed WAH relocation site, is mostly the site of the U.S. Food and Drug Administration campus).

Zip Code 20901: In zip code 20901, HCH projected WAH would experience only a 50% market share shift away from its current ED market share because portions of 20901 are in close proximity to the relocation site at White Oak, yet HCH remains much closer in average drive time and the strong market leader with 60% share.

Zip Code 20904: In zip code 20904, the new "home" zip code for the proposed relocated WAH, HCH projected a 17 point positive market share shift toward WAH.

Zip Code 20740: Finally, in zip code 20740, where three hospitals currently have roughly equal market share, HCH used WAH's prediction of expected MSGA volume shift. The projected ED volume shifts in the eight zip codes comprising the WAH PSA account for most of the volume shift with 12,994 ED visits appropriated to HCH. A similar methodology was used for projecting shifts in the WAH SSA (307 ED visits).

			9 Months CY 2014									WAH Projections After Relocation				HCH Projections After WAH Relocation				
												WAH New Market Share & Volume				WAH New Market Share & Volume				HCH New Volume
Zip Code	City	Service Area	Total Market ED Visits	Total Market ED Visits Annualized	Top Hospital	ED Market Share	Second Hospital	ED Market Share	Third Hospital	ED Market Share	WAH	ED Market Share	WAH volumes based on Current Share annualized	WAH MSGA share point shift	WAH proposed new share after move	WAH volumes with new market share annualized	Annual volume shift away / (towards) WAH	HCH projeced shift of share point s based after relocation	WAH proposed new share after move	WAH volumes with new market share annualized	Annual volume shift away / (towards) WAH	Annual volume shift toward / (away) HCH
20783	Hyattsville	PSA	10,555	14,073	WAH	60.32%	Holy Cross	25.01%	PGHC	4.43%			8489	-15%	45%	6,378	2,111	-57%	3%	424	8065	5081
20912	Takoma Park	PSA	6,091	8,121	WAH	66.18%	Holy Cross	25.22%	Suburban	1.66%			5375	-15%	51%	4,156	1,218	-63%	3%	269	5106	3778
20782	Hyattsville	PSA	5,412	7,216	WAH	53.14%	Holy Cross	17.94%	PGHC	10.75%			3835	-15%	38%	2,752	1,082	-50%	3%	192	3643	1384
20903	Silver Spring	PSA	5,872	7,829	Holy Cross	49.17%	WAH	40.50%	Suburban	1.98%			3171	3%	43%	3,406	(235)	-38%	2%	159	3012	2470
20901	Silver Spring	PSA	7,353	9,804	Holy Cross	64.69%	WAH	22.40%	Suburban	4.08%			2196	5%	27%	2,686	(490)	-11%	11%	1098	1098	911
20904	Silver Spring	PSA	13,074	17,432	Holy Cross	60.08%	WAH	11.66%	Montgomery Gen	10.43%			2032	45%	57%	9,876	(7,844)	17%	28%	4936	(2904)	(1974)
20740	College Park	PSA	3,910	5,213	Doctors	27.80%	WAH	24.35%	Holy Cross	20.38%			1269	-1%	23%	1,217	52	-1%	23%	1217	52	14
20910	Silver Spring	PSA	7,282	9,709	Holy Cross	65.60%	WAH	18.03%	Suburban	7.40%			1751	-15%	3%	294	1,456	-17%	1%	88	1663	1331
20705	Beltsville	SSA	5,572	7,429	Laurel	35.07%	Holy Cross	30.60%	WAH	12.94%			961	10%	23%	1,704	(743)	0%	13%	961	0	0
20011	Washington	SSA	2,693	3,591	WAH	30.75%	Holy Cross	25.92%	PGHC	8.73%			1104	-17%	14%	494	610	-29%	2%	55	1049	399
20737	Riverdale	SSA	5,090	6,787	Doctors	40.71%	PGHC	25.13%	WAH	14.48%			983	-15%	0%	-	983	-15%	0%	0	983	0
20902	Silver Spring	SSA	10,689	14,252	Holy Cross	73.37%	Suburban	7.68%	Montgomery Gen	7.15%	WAH	4.39%	625	0%	4%	625	-	0%	4%	625	0	0
20770	Greenbelt	SSA	5,983	7,977	Doctors	58.30%	Holy Cross	10.23%	WAH	7.82%			624	2%	10%	784	(160)	0%	8%	624	0	0
20784	Hyattsville	SSA	7,624	10,165	Doctors	45.13%	PGHC	32.73%	Holy Cross	6.96%	WAH	5.29%	537	-1%	4%	436	102	-1%	4%	436	102	7
20706	Lanham	SSA	9,432	12,576	Doctors	63.35%	PGHC	13.30%	Holy Cross	6.24%	WAH	3.68%	463	-1%	3%	337	126	-1%	3%	337	126	8
20781	Hyattsville	SSA	2,338	3,117	PGHC	29.90%	Doctors	26.22%	WAH	23.52%			733	-15%	9%	266	468	-21%	2%	73	660	0
20906	Silver Spring	SSA	17,054	22,739	Montgomery Gen	43.68%	Holy Cross	38.67%	SGAH	6.32%	WAH	2.43%	553	5%	7%	1,690	(1,137)	5%	7%	1690	(1137)	(455)
20712	Mount Rainier	SSA	1,236	1,648	WAH	45.39%	PGHC	19.82%	Holy Cross	11.97%			748	-20%	25%	418	330	-41%	5%	75	673	148
20785	Hyattsville	SSA	11,043	14,724	PGHC	52.26%	Doctors	28.66%	SMHC	3.41%	WAH	2.63%	387	-1%	2%	239	147	-1%	2%	239	147	0
20012	Washington	SSA	1,055	1,407	WAH	40.47%	Holy Cross	38.39%	Suburban	5.59%			569	-15%	25%	358	211	-36%	4%	57	512	323
20707	Laurel	SSA	8,516	11,355	Laurel	63.70%	HCGH	14.42%	Holy Cross	6.29%	WAH	2.22%	252	5%	7%	820	(568)	5%	7%	820	(568)	(34)
20708	Laurel	SSA	6,791	9,055	Laurel	64.32%	HCGH	9.59%	Holy Cross	5.89%	WAH	1.96%	177	1%	3%	268	(91)	1%	3%	268	(91)	(5)
20722	Brentwood	SSA	1,081	1,441	PGHC	37.19%	WAH	22.20%	Doctors	19.98%			320	-15%	7%	104	216	-15%	7%	104	216	0
20743	Capitol Heights	SSA	10,640	14,187	PGHC	46.10%	Doctors	22.28%	SMHC	15.68%	WAH	1.26%	179	-1%	0%	37	142	-1%	0%	37	142	0
20019	Washington	SSA	5,112	6,816	PGHC	42.06%	FWMC	13.22%	Doctors	12.25%	WAH	3.93%	268	-6.5%	0%	-	268	-7%	0%	0	268	0
20017	Washington	SSA	660	880	WAH	28.64%	Holy Cross	16.97%	PGHC	15.30%			252	-17%	12%	102	150	-29%	0%	0	252	60
20020	Washington	SSA	3,752	5,003	FWMC	32.14%	SMHC	21.88%	PGHC	16.36%	WAH	6.08%	304	-10.1%	0%	-	304	-10%	0%	0	304	0
20002	Washington	SSA	1,701	2,268	PGHC	23.16%	FWMC	12.87%	SMHC	11.82%	WAH	8.47%	192	-14.1%	0%	-	192	-14%	0%	0	192	0
20710	Bladensburg	SSA	2,675	3,567	PGHC	48.64%	Doctors	29.79%	WAH	8.15%			291	-1%	7%	255	36	-7%	1%	29	262	0
20018	Washington	SSA	814	1,085	PGHC	21.38%	WAH	15.48%	Holy Cross	13.51%			168	-17%	0%	-	168	-17%	0%	0	168	47
20866	Burtonsville	SSA	2,640	3,520	Holy Cross	34.05%	Laurel	23.37%	Montgomery Gen	14.66%	WAH	5.53%	195	15%	21%	723	(528)	15%	21%	723	(528)	(190)
													39,003			40,426	(1,424)			15,535	23,468	

PSA Shift	12994
SSA Shift	307
TSA Shift	13302

Notes:

[1] Includes Pediatrics <18 years

[2] ED visits defined by Inpatient and Outpatient cases with EMG rate center charges > 0

[3] Service Area defined as WAH current PSA/SSA, as submitted in the CON (page 102)

[4] Does not inclued out of service area visit volume

EXHIBIT 3

Urgent Care Centers in Montgomery County

10 Centers Opened Between 2012 - 2015
14 Centers Opened Between 2000 - 2011

Count	City/Center Name	Address	Date Opened
	Bethesda:		
1	Jivana Urgent Care	4314 Montgomery Avenue, Bethesda, MD 20814	2000
2	Med One, LLC	7930 Old Georgetown Road, Bethesda, MD 20814	2011
	Clarksburg:		
3	Clarksburg Medical Center	23208 Brewers Tavern Way, Clarksburg, MD 20871	2002
	Gaithersburg:		
4	All Day Medical Care	8945 N Westland Drive, Gaithersburg, MD 20877	2010
5	MedStar Prompt Care	12111 Darnestown Rd., Gaithersburg, MD 20878	Open 2.5 years
6	RightTime Medical Care	882 Muddy Branch Rd., Gaithersburg, MD 20878	Jun-09
7	Secure Medical Care	803 Russell Ave., Gaithersburg, MD 20879	unknown
8	Doctors First	806 West Diamnod Avenue, Suite 110, Gaithersburg, MD	301-515-2901
9	Kaiser Permanente	655 Watkins Mill Road, Gaithersburg, MD 20879	2012
10	Patient First Urgent Care - Montgomery Village	1910 Montgomery Village Avenue, Gaithersburg, MD 20886	Opening in 2016
	Germantown:		
11	Doctors First Walk-In	19785 Crystal Rock Drive, Germantown, MD 20874	2008
12	Medical Access (old location moved to Middlebrook Road)	19504 Amaranth Dr., Germantown, MD 20874	1999
13	Medical Access (new location relocated from Amaranth Dr.)	12321 Middlebrook Road, Germantown, MD 20874	2013 (been in current location 2 years)
14	RightTime Medical Care	19777 Frederick Road, Germantown, MD 20876	2015
15	Adventist Healthcare Germantown Emergency Center (Urgent & Emergency Care)	19731 Germantown Road, Germantown, MD 20874	2007
16	Germantown Centra Care Adventist HealthCare Urgent Care	19993 N. Frederick Road, Germantown MD	Opening Soon
	Kensington:		
17	Fast Track Urgent Care	10540 Connecticut Ave., Kensington, MD 20895	2008
18	Kaiser Permanente	10810 Conneticut Ave., Kensington, MD 20895	unknown
	Olney:		
19	RightTime Medical Care	18045 Georgia Ave., Olney, MD 20832	2011
	Potomac:		
20	**First Clinic Urgent Care Clinic**	Potomac Medical Arts Center, 9800 Falls Road, Potomac, MD 20854	2009
	Rockville:		
21	Montgomery Emergency Physicians	9901 Medical Center Dr., Rockville, MD 20850	2008
22	Patient First	718 Rockville Pike, Rockville, MD 20852	Jun-15
23	Physicians Now, LLC	15215 Shady Grove Rd., Rockville, MD 20850	unknown
24	RightTime Medical Care	12220 Rockville Pike, Rockville, MD 20852	2003
25	After Hours Urgent Care	751 Rockville Pike, Rockville, MD 20852	unknown
26	Rockville Centra Care	Rockville, MD 20852	unknown
27	Ace Medical Clinic	11520 Rockville Pike, MD 20852	unknown
28	Rockville Centra Care, Adventist HealthCare Urgent Care	750 Rockville Pike, Rockville, MD 20852	2014
	Sandy Spring:		
29	Primemed Urgent Care Services	900 Olney Sandy Spring Road, Sandy Spring, MD 20860	2007
	Silver Spring:		
30	Metro Immediate and Primary Care Services - GW Medical Faculty Assoc.	8484 Georgia Avenue, Silver Spring, MD	No Answer - Answering Svc Only
31	The Doctors Next Door Urgent Care	10801 Lockwood Dr., Silver Spring, MD 20901	2013
32	Fast Track Urgent Care	13428 New Hampshire Avenue , Silver Spring, MD 20904	2013
33	Briggs Chaney Total Health Clinic Urgent Care	13823 Outlet Dr., Silver Spring, MD 20904	Greater than 25 years
34	Advanced Walking Urgent Care	10801 Lockwood Dr., Silver Spring, MD 20901	No Answer - Answering Svc Only
35	Langley Park Walk-In Medical	1040 University Blvd, E, Silver Spring, MD 20903	30 years
36	Patient First	8601 16th Street, Silver Spring, MD 20910	Oct. 2013
37	RightTime Medical Care	20 University Blvd, E, Silver Spring, MD 20901	Aug-14
38	Xpress Medcare, LLC	13671 Georgia Ave., Silver Spring, MD 20906	2011
39	MedStar Prompt Care	11915 Georgia Avenue, Silver Spring, MD 20902	unknown
	Wheaton:		
40	MedStar PromptCare	11915 Georgia Ave, Wheaton, MD 20902	Dec. 2012

Sources:
https://www.urgentcarelocations.com/md

MHCC

http://www.yellowpages.com/damascus-md/walk-in-clinic

Removed Minute Clinics and Target Clinic (Cherry Hill Rd, Silver Spring) as they are not urgent care centers; they provide minor care