456th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION OF THE

HEALTH SERVICES COST REVIEW COMMISSION

May 13, 2009

8:00 a.m.

1. **Review of the Public Minutes of April 15, 2009**

2. **Executive Director's Report**

3. **Docket Status - Cases Closed**

   2014A - Johns Hopkins health system
   2017A - University of Maryland Medical System
   2018R - University Specialty Hospital
   2019N - Garrett County Memorial Hospital
   2020R - Franklin Square Hospital
   2024A - University of Maryland Medical System

4. **Docket Status - Cases Open**

   2009A - University of Maryland Medical Center
   2021R - Johns Hopkins Bayview Medical Center
   2022R - Civista Medical Center
   2023A - University of Maryland Medical Center
   2025N - Johns Hopkins Hospital
   2026N - The Edward W. McCready Memorial Hospital
   2027R - Good Samaritan Hospital

5. **Final Recommendations from the Deliberations of the Payment Work Group**

6. **Final Recommendation for changes to the Quality-Based Reimbursement Project**

7. **Draft Revised Recommendations on HSCRC Payment Policy for Highly Preventable Hospital Acquired Conditions**

8. **Draft Recommendations on Maryland Patient Safety Center Funding for FY 2010**

9. **Final Recommendations for FY 2010 Nurse Support II and Competitive Institutional Grants**

10. **Legal Report**

11. **Hearing and Meeting Schedule**

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

AS OF MAY 5 , 2009

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2009A	University of Maryland Medical Center	11/17/08	N/A	N/A	ARM	DNP	OPEN
2021R	Johns Hopkins Bayview Medical Center	3/6/09	5/13/09	8/4/09	CAPITAL	GS	OPEN
2022R	Civista Medical Center	3/25/09	5/26/09	8/23/09	ICU/CCU	CO	OPEN
2023A	University of Maryland Medical Center	4/2/09	N/A	N/A	ARM	DNP	OPEN
2025N	Johns Hopkins Hospital	4/16/09	5/16/09	9/14/09	AUD	CO	OPEN
2026N	The Edward W. McCready Memorial Hospital	4/27/09	5/27/09	9/24/09	RDL	CO	OPEN
2027R	Good Samaritan Hospital	5/1/09	5/31/09	9/28/09	ICU/CCU	CO	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2008**
MEDICAL CENTER	*	**FOLIO:**	**1819**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2009A**

Staff Recommendation

May 13, 2009

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed a renewal application with the HSCRC on November 17, 2008 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ and blood and bone marrow transplant services with United Resource Networks for a one-year period effective November 1, 2008.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

When the Hospital applied for renewal last year, the experience under this arrangement for the prior year (FY 2008) was unfavorable. Representatives of the Hospital understood that renewal of this arrangement would not be recommended by staff unless changes took place that would allow for payments to be commensurate with costs. Subsequently, the following changes occurred: 1) the Hospital negotiated contract improvements including, among other things, an overall rate increase and lower outlier threshold days; 2) the Hospital was the beneficiary of a favorable change in the HSCRC's organ acquisition overhead allocation methodology that would result in lower Hospital charges for organ acquisition ; and 3) the Hospital initiated of clinical cost-of-care reductions.

Consequently, staff delayed its recommendation until finalized experience data for FY 2009 could be obtained. Those data indicate favorable experience for the first half of FY 2009.

VI. STAFF RECOMMENDATION

After review of the terms of the re-negotiated arrangement and the favorable performance for the first half of FY 2009, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period retroactive to November 1, 2008. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
CIVISTA MEDICAL	*	DOCKET: 2009
CENTER	*	FOLIO: 1832
LAPLATA, MARYLAND	*	PROCEEDING: 2022R

* *

Staff Recommendation

MAY 13, 2009

Introduction

On March 23, 2009, Civista Medical Center (the "Hospital") submitted a partial rate application to the Commission requesting its July 1, 2008 Medical Intensive Care Unit (MIS) and Coronary Care Unit (CCU) approved rates be combined effective April 1, 2009. This rate will not result in any additional revenue for the Hospital, as it only involves the combining of two revenue centers. The Hospital wishes to combine the two centers because their respective patients have similar staffing needs, and placement into an ICU or CCU unit is often based on bed availability or staffing rather than on a diagnosis. The Hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical/Surgical ICU	$1,878.46	2,985	$5,607,198
Coronary Care	1,885.21	1,216	2,292,411
Combined Rate	1,880.41	4,201	7,899,610

Recommendation

After reviewing the Hospital's application, the staff recommends that the Hospital be allowed to collapse its Coronary Care rate into its Medical Intensive Care rate effective April 1, 2009.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND	*	DOCKET:	2009
MEDICAL CENTER	*	FOLIO:	1833
BALTIMORE, MARYLAND	*	PROCEEDING:	2023A

Staff Recommendation

May 13, 2009

I. INTRODUCTION

University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on April 2, 2009 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver and blood and bone marrow transplants for a period of three years with Cigna Health Corporation beginning July 1, 2009.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2009. The Hospital will need to file a renewal application to be considered for continued participation.

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

IN RE: THE PERMANENT RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
JOHN HOPKINS	*	**DOCKET:**	**2009**
HOSPITAL	*	**FOLIO:**	**1835**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2025N**

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Staff Recommendation

May 13, 2009

Introduction

On April 15 2009, Johns Hopkins Hospital (the "Hospital") submitted a partial rate application to the Commission request Audiology (AUD) services. The Hospital is requesting that the AUD statewide median rate be approved effective May 15, 2009.

Staff Evaluation

To determine if the Hospital's rate should be set at the statewide median rate or at a rate based on its projected costs, the staff requested that the Hospital submit to the Commission its cost and volume projections for FY 2009. Based on the information received, staff determined that the AUD rate based on the Hospital's projected data is $5.23 per RVU, while the statewide median for AUD services is $11.23 per RVU.

Recommendation

After reviewing the Hospital's application, the staff has the following recommendations:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 days prior to the opening of the new service be waived;
2. That the AUD rate of $ 5.23 per RVU be approved effective May 15, 2009;
3. That no change be made to the Hospital's charge per case standard for AUD services; and
4. That the AUD rate not be rate realigned until a full year's experience data have been reported to the Commission.

Final Staff Recommendation and Discussion Document Regarding the FY 2010 HSCRC Hospital Payment Update

Health Services Cost Review Commission
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May 13, 2009

This document represents a final recommendation to be presented to the Commission on May 13, 2009 for action by the Commission.

Background

In November of this fiscal year, the staff assembled a "Payment Workgroup" to assist staff in the development of a draft recommendation for an inflation update to hospital rates for FY 2010 (effective July 1, 2009). This Workgroup consisted of representatives of HSCRC, staff, the Maryland Hospital Association (MHA) and individual hospitals, and public and private payers (including representatives from CareFirst of Maryland, Kaiser-Permanente, United Health Care, Amerigroup, Maryland Medicaid and the State Employee Benefit Program). The goal of this effort was to develop a consensus position on the level of the hospital update for the years FY 2010-2012.[1]

Given that total hospital revenues currently approximate $13 billion annually, the magnitude of the HSCRC's annual hospital rate update has significant implications for both the financial condition of Maryland hospitals and the affordability of hospital care within the State. Each 1.0% additional increment in the update represents approximately $130 million in annual hospital payments. The Maryland Medicaid program represents approximately 15% of the hospital market and, thus, every 1.0% increase in the annual update will increase Medicaid hospital payments by approximately $20 million. Thus, hospital rate increases have a large impact on the State budget by way of increases in Medicaid hospital payments. It should also be noted that hospital payments (and thus the revenues hospitals generate) are also influenced by changes in the volume of services year to year. In recent years, growth in hospital volume (largely additional admissions and hospital visits) has ranged from 1.0% to 3.0% per year. Annual increases in volumes for the year FY 2009 are expected to be on the lower end of that spectrum – approximately 1.0% over FY 2008 levels.

Despite a slowing of volume growth, health care expenditures in the US continue to increase as a percentage of overall Gross Domestic Product (GDP) accounting for an estimated 18% of GDP nationally.[2] This proportion of GDP (which is more than double that of other developed countries around the world) has continued to grow over the past several decades and is increasing at an accelerated rate given current and projected contractions in the rest of the economy. Hospital expenditures are a significant component of overall health spending, account for approximately 36% of overall health spending.[3] Given these factors, there is heightened concern over the economic sustainability of historical cost growth trends in Maryland and in the rest of the country.

In order to provide the HSCRC with sufficient time to receive input from all parties and deliberate over this decision, the HSCRC Chairman requested that the staff provide the Commission with a draft proposal for the FY 2010 update at the April public meeting (which was presented and discussed at the April 15th public meeting along with payment update proposals from both the payer and hospital industries). In past years, hospitals have also expressed a strong desire for the Commission to discuss and decide on the next year's update factor prior to the completion of hospitals' budgeting process, which generally occurs in the March to May time frame. Given these circumstances, the staff requested update proposals from both payer and hospital representatives beginning in November 2008. More accelerated discussions have taken place since early March of 2009 in order to meet the Chairman's directive to present a staff draft recommendation to the Commission by the April meeting. The Payment Workgroup has continued to meet since the April Commission meeting.

Update Proposals from Hospitals and Payers

Due to concerns regarding the uncertainty associated with the economy and the financial markets, MHA put forth a rate proposal that applied only to this upcoming rate year FY 2010. Given these circumstances the MHA strongly suggested that the Commission consider a one-year update arrangement (in the past the HSCRC has

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[1] The Payment Work Group convened last year successfully forged a near consensus recommendation for a 4.7% rate update for FY 2009 rates over FY 2008.

[2] Congressional Budget Office and MHCC Health Spending Accounts 2008

[3] MHCC Health Spending Accounts 2008

adopted update proposals covering a three-year time horizon). The hospital proposal was for a blended (both inpatient and outpatient) base update of 3.34% over FY 2009 rate levels. This proposal included estimated input cost inflation (or "Market Basket") and expected case mix increases (expected year-to-year increases in the illness burden of patients due to aging of the population and other factors). This current MHA proposal includes a 0.53% adjustment to the base factor cost inflation estimate to account for a historical forecasting error associated with this measure and an additional 0.70% "financial condition" adjustment over and above base input cost inflation (to help cover expected additional costs stemming from the current volatility in the financial markets). Assuming base revenue of $12.9 billion for FY 2009, when including an expected increase in hospital volumes of 0.99% this proposal would increase hospital payments in FY 2010 by $559 million over the FY 2009 base.[4]

In response to the original staff request, the payer representatives initially proposed a three-year rate arrangement. This proposal was subsequently withdrawn, however, when staff concurred with the MHA view that given market and economic conditions the rate update proposals should apply only to the upcoming rate year, FY 2010. The payer one-year proposal was for a 0.88% update to hospital rates for FY 2010. This proposal along with anticipated volume increases would result in a $241 million increase in hospital payments over FY 2009. **Table 1** below summarizes both the MHA and the payer proposals for the HSCRC update factor for FY 2010.

Table 1
Hospital and Payer One-Year Payment Update Proposals

Payment Proposals as of 4/22/09

	Payer	Revised MHA Proposal April 22
1 Market Basket	0.00%	1.59%
2 Forecast Error	NA	0.53%
3 Productivity	NA	NA
4 Finaniclal Condition Adjustment	NA	0.70%
5 Subtotal	0.00%	2.82%
6 "Projected Slippage 2010"	0.10%	-0.10%
7 **Base Update**	**0.10%**	**2.72%**
8 Volume Adjustment (1)	-0.22%	-0.22%
9 Case mix	1.00%	0.75%
10 **Final Update**	**0.88%**	**3.25%**
11 Blended I/P and O/P Update	0.88%	3.34% (2)
12 Expected Volume growth 2010 (3)	0.99%	0.99%
13 **Overall Projected Revenue Increas**	**1.87%**	**4.33%**
14 Expected Overall Revenue Increase	$241 million	$559 million

(1) Volume adjustment is based on a projection YE 2009 based on 9 months YTD data
(2) MHA proposal included an additional 0.3% intensity adjustment for Outpatient
(3) Expected volume increases for FY 2010 based on forecasted FY 2009 volume growth

[4] It should be noted, this is a revised proposal. At the April 22nd meeting of the payment work group, the MHA reduced their proposal from a blended 3.84% total update to 3.34% (a reduction of 0.5%). The staff and payer proposals remain unchanged.

In addition to a proposal for the core rate update for FY 2010, both the hospital and payer proposals covered a number of related parameters and issues affecting next year's hospital rate structure. These include supplementary proposals related to differential "scaling" of updates by hospital based on relative efficiency, retention of the 7% minimum threshold for the Medicare Waiver test, the handling of volume adjustments in the system, adjustments for so-called "system slippage" (departures from the targeted hospital revenue increase due full rate reviews and spenddowns) and other factors. A description of these additional parameters and the respective payer, hospital and staff proposals will be provided in a later section. The current payer proposal is shown in more detail in **Appendix I** (the staff had not received a document detailing the hospital proposal – update, scaling and other provisions – by the time this document was finalized).

HSCRC Staff Draft Update Proposal

Given the very large difference between the proposals, it became clear to staff that it would be difficult to develop a consensus position for the Payment Workgroup. Accordingly, the staff examined the two industry proposals and a number of other environmental factors in the development of its own draft proposal for an update to hospital rates effective July 1, 2009 (for FY 2010). This evaluation provided the basis for the staff's current draft recommendation.

Environmental Factors Considered:

Hospital Financial Performance: Hospital operating performance in 2009 is generally stable, but the overall (both operating and non-operating) profit and cash position of hospitals have been negatively affected by large non-operating losses (both realized and unrealized). First, operating performance of Maryland hospitals has remained quite healthy and stable over the past two fiscal years 2007 and 2008, with some slight deterioration in 2008 (based on an analysis of 41 June Year End hospitals). This deterioration was primarily related to an increase in losses hospitals experienced on their unregulated portions of their business.[5] **Table 2a** shows that while regulated operating margins remained relatively stable between 2007 and 2008 (5.5% in 08 vs. 5.7% in 07), losses on unregulated services increased from -22% in 07 to -30.1% in FY 2008 (accounting for nearly all of the deterioration in total operating margin) resulting a reduction of combined margins from 3.23 in FY 2007 to 2.4% in FY 2008. A breakdown of unregulated losses for FY 2008 is provided in **Appendix II.**

For the current year (FY 2009) it appears that operating profitability has improved over FY 2008 levels. Year-to-date operating performance in FY 2009 (both regulated and overall operating profits), are higher than operating profits last year at this time (2.34% total operating profit for first 9 months of 2009 vs. 2.15% total operating profit for first 9 months of 2008).[6] This indicates to staff that Maryland hospitals are still likely generating regulated operating profits in excess of 5.0% this year (as was the case in FY 2008). These results are summarized in **Table 2b** below.

[5] Unregulated losses are largely losses on physician services but also include other non-hospital lines of business. **Appendix II** provides a summary of 2008 unregulated losses by hospital.

[6] Note: While year-to-date FY 2009 unaudited F/S data do accurately reflect final audited financial performance for hospitals (once audited financials are received) there is some inconsistency in the way hospitals account for regulated and unregulated revenues and expenses on the F/S YTD unaudited reports.

Tables 2a and 2b

Table 2a FY 2008 vs. FY 2007 Operating Performance (41 June Year End Hospitals)

	FY 2007 June Year End Hospitals			FY 2008 June Year End Hospitals		
	Regulated	Unregulated	Total	Regulated	Unregulated	Total
Operating Profit	5.70%	-22.00%	**3.23%**	5.50%	-30.10%	**2.40%**
Note: If unregulated loss had stayed constant in 2008				5.50%	-22.00%	**3.13%**

Source: Annual Cost Report filings to HSCRC (reconciled with audits)

Note: Last year YTD performance resulted in robust operating margins on the hospitals' regulated portion of their business. YTD 2009 overall operating performance is nearly identical to YTD 2008.

Table 2b Last Year (2008 YTD) vs. Current Year (2009 YTD) Operating Performance

	Last Year at this Time 9 months through March 2008	Current Year 9 months through March 2009
	Total	Total
Total Operating Profit (both regulated and unregulated)	2.15%	**2.34%**(1) Higher than 2008

(1) Steady operating profits for 2009 are indicative of a similar profile of regulated and unregulated profit picture for hospitals in 2009. Anecdotal reports are that unregulated losses have increased again in 2009 which would mean that regulated operating profilts may well be higher in FY 2009 than in FY 2008.

Source: Monthly Unaudited financial statements filed with the HSCRC

While overall operating performance remains stable, hospitals (along with most other businesses) have experienced large non-operating losses in FY 2009. These non-operating losses include both realized losses from investments (owing largely to liquidated equity positions following the large declines in the equity market) and unrealized losses from current investments, and large "mark-to-market" swap liabilities associated with interest rate swaps on the balance sheets of hospitals. A breakdown of these non-operating losses for 2009 (through January) is provided in **Appendix III.** The primary impact of these realized and unrealized losses is that they place pressure on the liquidity position of hospitals in that: 1) investment declines directly reduce cash positions; and 2) unrealized losses related to swap arrangements trigger collateral calls (the requirement that hospitals post additional cash as collateral as the magnitude of swap liabilities increase). A related concern is that material swap liabilities in combination with investment losses, could lead to a borrower violating bond covenants (such as liquidity covenants) which can lead to acceleration of principal payments or immediate repayment of principal.

Combined with poor investment returns in 2009, many hospitals in the US are challenged by the sudden reduction in liquidity that swap liabilities can cause. The MHA attempted to quantify this reduction in cash positions for FY 2009 and estimated that Maryland hospitals may have experienced a reduction in cash in excess of 20% relative to 2008 levels. For hospitals affected by both of these risks and unable to maintain operating margins, rating downgrades are possible. Bond rating agencies are aware of these circumstances have tended to place stressed institutions on "negative watch" rather than immediately inflicting a ratings downgrade. If hospitals hold these swap arrangements to maturity however, the unrealized balance sheet loss will evaporate. Thus, the posting of collateral may be temporary depending upon market conditions. **Appendix IV** provides a

more complete analysis from Moody's Investor Services of the impact these swap arrangements are having on hospitals' liquidity position and bond ratings.

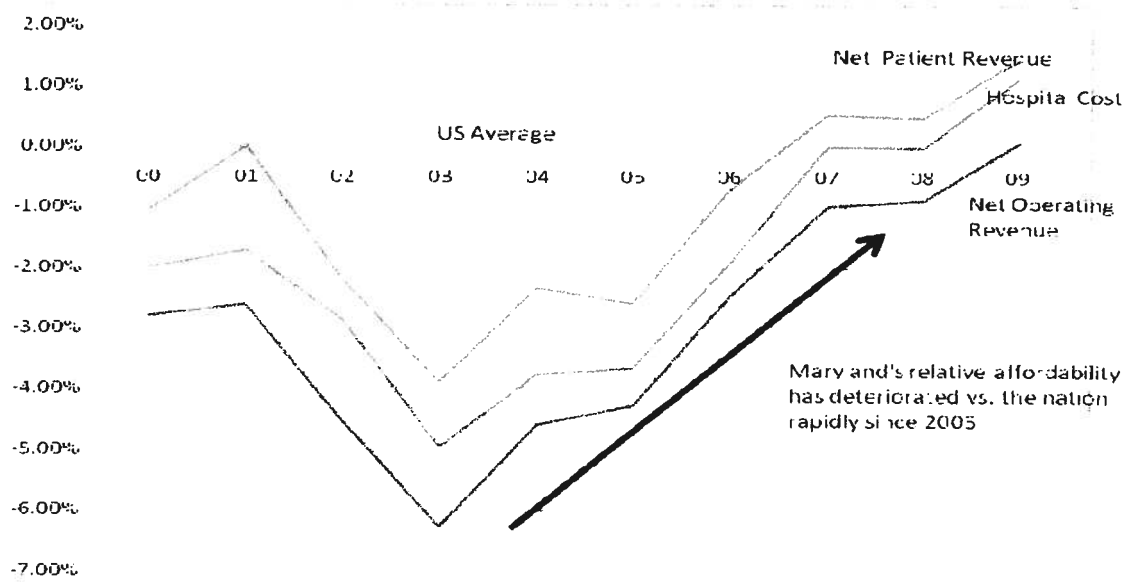
Severe Contraction in the General Economy: General economic activity nationwide is in a state of "severe contraction" with national GDP estimated to have declined by 6.2% on an annualized basis for the last quarter of CY 2008. Preliminary estimates for first quarter CY 2009 showed this magnitude of economic slowdown was continuing through March of this year. This contraction has impacted virtually all sectors of the economy. The growing un-affordability of hospital services has been a large concern of the HSCRC in recent years. This recent contraction in economic activity means that health care services have become even less affordable. This dynamic is particularly pronounced in Maryland relative to the rest of the U.S. because hospital payments and costs have increased more rapidly here than in the rest of the country over the past 4-5 years. **Table 3 and Chart 1** below summarizes this unfavorable trend.

Table 3
Erosion of Maryland Hospital Payments and Costs vs. US Hospitals

	AHA Actual 2000		AHA Actual 2001		AHA Actual 2002		AHA Actual 2003		AHA Actual 2004		AHA Actual 2005		AHA Actual 2006		AHA Actual 2007		HSCRC Estimated 2008		HSCRC Estimated 2009	
Net Operating Revenue per EIPA		Growth		Growth		Growth		Growth		Growth		Growth		Growth		Growth		Growth		Growth
US (per AHA)	$7,116	5.20%	$7,486	6.65%	$7,984	6.66%	$8,516	5.39%	$8,975	5.24%	$9,445	5.06%	$9,923	5.37%	$10,456	5.30%	$11,010	4.00%	$11,451	
Maryland (per AHA)	$6,917	5.41%	$7,291	4.57%	$7,624	4.70%	$7,982	7.28%	$8,563	5.58%	$9,041	7.06%	$9,679	6.96%	$10,353	5.41%	$10,913	5.00%	$11,459	
Maryland Above/Below	-2.80%		-2.60%		-4.51%		-6.27%		-4.59%		-4.28%		-2.46%		-0.99%		-0.88%		0.07%	
Net Patient Revenue per EIPA																				
US Hospitals (per AHA)	$6,689	5.17%	$7,035	6.81%	$7,514	6.59%	$8,009	5.57%	$8,455	5.43%	$8,914	4.80%	$9,342	5.34%	$9,841	5.50%	$10,382	4.00%	$10,798	
Maryland Hospitals (per AHA)	$6,620	6.30%	$7,037	4.45%	$7,350	4.73%	$7,698	7.29%	$8,259	5.15%	$8,684	6.82%	$9,276	6.65%	$9,893	5.46%	$10,433	5.00%	$10,955	
Maryland Above/Below	-1.03%		0.03%		-2.18%		-3.88%		-2.32%		-2.58%		-0.71%		0.53%		0.49%		1.46%	
Cost per EIPA																				
US Hospitals (per AHA)	$6,996	4.55%	$7,314	5.51%	$7,717	6.69%	$8,233	5.25%	$8,665	5.01%	$9,099	5.12%	$9,565	4.85%	$10,029	5.10%	$10,540	4.00%	$10,962	
Maryland Hospitals (per AHA)	$6,856	4.84%	$7,188	4.26%	$7,496	4.38%	$7,824	6.56%	$8,339	5.13%	$8,767	7.00%	$9,381	6.90%	$10,028	5.09%	$10,538	5.18%	$11,084	
Maryland Above/Below	-2.00%		-1.72%		-2.86%		-4.97%		-3.76%		-3.65%		-1.92%		-0.01%		-0.02%		1.11%	

Note: EIPA = Equivalent Inpatient Admission, is a proxy statistic for volume calculated on the basis of both inpatient and outpatient activity

Chart 1
Erosion of Maryland Hospital Payments and Costs vs. US Hospitals



The economic slowdown has however dramatically curtained the growth in factor costs however (the cost of inputs to the production process). Wage growth nationally is flat with many sectors starting to cut wages (in addition to layoffs and furloughs of employees). Flat or declining wages have created slack in the labor market, including the health care sector, which will help alleviated previous shortages of nurses and allied health professionals. A summary of reports about contractions in most sectors of the economy is contained in **Appendix V.**[7]

Trends in Hospital Input Cost Inflation: The current estimate (released in early April 2009) for increases in hospital input costs (increases in the inputs to the hospital production process) in the coming fiscal year FY 2010 is 1.59%. This forecast has remained unchanged from the previous estimate (from January 2009). The hospital input cost inflation estimate consists of both wage and non-wage components. Hospital wages, (accounting for 60% of hospital costs) were projected to increase at 2.7% while non wage items (accounting for 40% of hospital costs) were forecasted to grow at .10%. Given the increasing slack in the labor market across all sectors, staff believes hospitals may have the ability to further reduce their input cost growth by holding wage increases to levels below the projected levels in FY 2010. **Table 4** summarizes the estimated increases in hospital input costs by category.

Table 4 Global Insights Market Basket Components (hospital input cost inflation FY 2010)

Category	% increase	Weight
Compensation	2.70%	60.0%
Professional Fees	2.50%	6.0%
Malpractice	4.50%	2.0%
Utilities	-1.80%	1.0%
All Other costs	-0.60%	31.0%
Non- Capital	1.66%	
Capital	1.50%	
Weighted cost inflation	**1.59%**	

Significant State Budgetary Shortfalls: The State of Maryland continues to face significant budgetary shortfalls. The most recent write-down of projected State revenues (reflecting the general economic contraction) has resulted in an expected State budget shortfall in excess of half a billion dollars for FY 2010. It is expected that any additional contraction in economic activity during the course of 2009 and 2010 will result in larger budget deficits. Accordingly, the budget for FY 2010 Maryland Medicaid expenditures has been negatively impacted. Updates provided by the State Medicaid program to its non-hospital providers ranged between 0% and 0.9% for FY 2010. **Table 5** below summarizes the inflation updates provided by Medicaid to nursing homes, Personal Care, Private Duty Nurses, Medical Day Care Workers, Home Health, Living at Home Waiver, Waiver for Older Adult and Managed Care organizations and providers.

[7] Bureau of Economic Analysis and Federal Reserve District Reports February and March 2009

Table 5 Rate Updates for Medicaid Providers FY 2010

Proposed Medicaid Provider Rate Increases included in FY 2010 Budget

Managed Care Organizations *	
Personal Care	0.0%
Nursing Homes	0.0%
Private Duty Nursing	0.0%
Medical Day Care Waiver	0.9%
Home Health	0.0%
Living at Home Waiver	0.9%
Waiver for Older Adults	0.9%
Dentists	0.0%
Physicians	-1.0%

* 4.3% in first six months and 0% in second six months (due to budgeting process)

Deterioration in Medicare Waiver: The HSCRC recently received notice of an unexpected deterioration in its Medicare Waiver test for the period ending December 2007. This lower than expected result also was apparent in the subsequent test result for the Year Ending March 2008 (received last week). The State must pass this financial test in order to retain its ability to have Medicare participate in the All-Payer system. Medicare's participation results in the equitable sharing of the cost of Uncompensated Care (some $980 million per year). Overall, the Medicare Waiver results in over $1 billion per year in enhanced federal reimbursements to Maryland hospitals. The most recent Waiver test (covering the year ending March 2008) shows Maryland at its lowest waiver cushion ever – a relative margin of 6.61%.

As mentioned at the April Commission meeting, staff has been meeting with the CMS actuary regarding a separate set of more technical issues that staff believes (if appropriately adjusted for by the actuary), could result in an improvement in our margin by 1-2%. While this is a favorable development, staff would point out that even if the margin improves by 2.0% (to 8.82%) this is still well below historical waiver margins and in staff's estimation constitutes a perilously thin cushion given the specter of large future Medicare cuts. Staff would further point out that Maryland's relatively high proportion of one-day length of stay cases (in Maryland over 20% of inpatient admissions are 1 day length of stay vs. the 14% of all admissions nationally) may result in more than a 2.0% deterioration in the Medicare waiver if some proportion of these one day admissions be found to have been more appropriately treated in an outpatient setting.

Table 6

Waiver Test Performance- Actual through March 08 & Projected based on MHA Magnitude Update

Medicare Waiver Test (Actual and Forecasted)
Relative Test Based on Actual data through March 2008

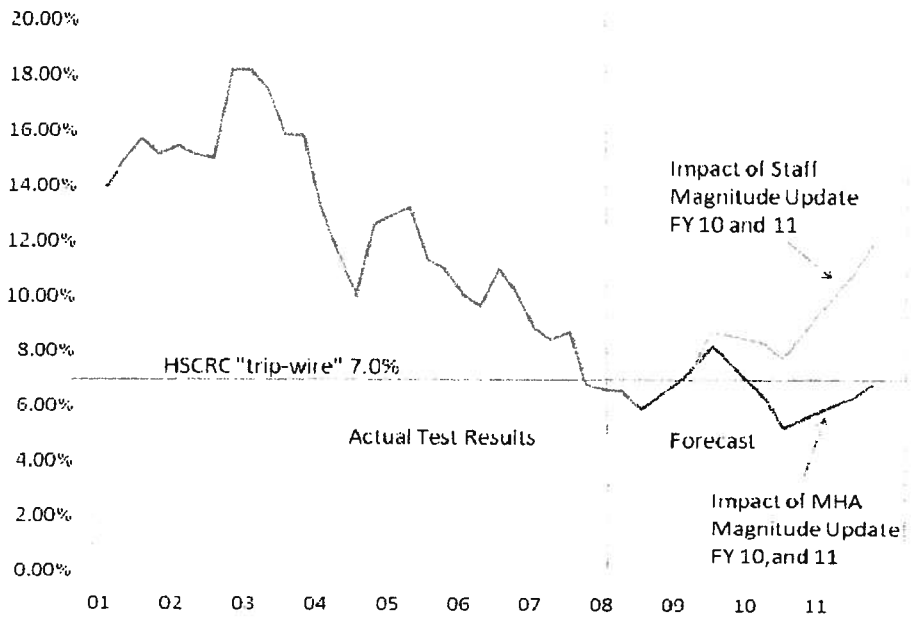
Qtr Ending	Federal Fiscal	Medicare Maryland Pmt/Case	Medicare U.S. Pmt/Case	Waiver Test Relative Margin	
YE M01		$8,187	$7,196	13.90%	
YE J01		$8,244	$7,309	14.89%	
YE S01		$8,275	$7,387	15.69%	
YE D01	FFY 02	$8,406	$7,468	15.14%	
YE M02		$8,471	$7,546	15.45%	
YE J02		$8,576	$7,620	15.15%	
YE S02		$8,655	$7,680	15.00%	
YE D02	FFY 03	$8,728	$7,959	18.18%	
YE M03		$8,728	$7,959	18.18%	
YE J03		$8,846	$8,019	17.48%	
YE S03		$9,035	$8,077	15.85%	
YE D03	FFY 04	$9,155	$8,185	15.86%	
YE M04		$9,319	$8,142	13.23%	
YE J04		$9,554	$8,227	11.59%	
YE S04		$9,681	$8,218	10.01%	
YE D04	FFY 05	$9,819	$8,535	12.64%	
YE M05		$9,895	$8,625	12.97%	
YE J05		$9,968	$8,713	13.28%	
YE S05		$10,107	$8,684	11.34%	
YE D05	FFY 06	$10,239	$8,770	11.00%	
YE M06		$10,453	$8,881	10.10%	
YE J06		$10,620	$8,986	9.65%	
YE S06		$10,785	$9,241	11.04%	
YE D06	FFY 07	$10,920	$9,282	10.16%	
YE M07		$11,137	$9,358	8.89%	
YE J07		$11,294	$9,451	8.44%	
YE S07		$11,352	$9,524	8.72%	
YE D07	FFY 08	$11,501	$9,480	6.82%	(1)
YE M08		**$11,604**	**$9,547**	**6.61%**	Actual
YE J08		$11,683	$9,608	6.58%	Projected
YE S08		$11,831	$9,672	5.95%	
YE D08	FFY 09	$11,963	$9,824	6.43%	(2)
YE M09		$12,095	$9,977	6.90%	
YE J09		$12,211	$10,129	7.49%	
YE S09		$12,306	$10,281	8.26%	
YE D09	FFY 10	$12,402	$10,298	7.61%	(3)
YE M10		$12,497	$10,316	6.97%	
YE J10		$12,593	$10,333	6.33%	
YE S10		$12,691	$10,310	5.28%	
YE D10	FFY 11	$12,789	$10,419	5.57%	(4), (5)
YE M11		$12,888	$10,528	5.87%	
YE J11		$12,986	$10,637	6.15%	
YE S11		$13,088	$10,746	6.41%	
YE D11		$13,189	$10,875	6.85%	

Notes: Forecast based on discussion with CMS actuary regarding future adjustments to original CMS actuary forecast provided to HSCRC Feb 2009.
(1) Original FFY 08 CMS actuary Forecasts largely unchanged
(2) FFY 09 US payments should increase by 0.5% over original forecast
(3) FFY 10 payments should decrease by 1.8% relative to original forecast
(4) FFY 11 payments should decrease by 1.8% relative to original forecast
(5) FFY 11 and FFY 12 must also include one-time reductions for overpayments in 08 & 09

The State has traditionally maintained a relative margin of between 12% - 15%. Given the likelihood of future and severe cuts in Medicare expenditures nationally, it is vital that the HSCRC seek to restore our cushion to a level of at least 10% over the next several years in order to withstand these cuts. **Table 6** (above) and **Chart 2** show the State's actual performance on the test 2001 – 2008 and staff forecast based on the most recent data and

information from CMS's actuary. The forecast shows two possible scenarios: a) the impact that a "MHA magnitude" update would have on the waiver test if adopted and FY 2010 and continued for FY 2011; and b) the impact that a "staff magnitude" update would have on the test if adopted in FY 2010 and continued for FY 2011.[8]

Chart 2
Actual and Forecast Waiver Test Performance



Medpac - March 2009 Observations: The most recent report of Medpac (the federal commission that advises Congress on Medicare payment issues) to Congress (March 2009) provides some useful information about current and future policy regarding Medicare hospital payment levels nationally.

Each year however, concern over the long term sustainability of Medicare has intensified as payment growth and projected enrollment increases are expected to result in large deficits in Medicare's Hospital Insurance trust fund in future years.[9] Based on these concerns, it is virtually certain that Congress will need to significantly reduce health expenditures in the coming years. Preliminary discussions regarding potential cuts are already occurring. The Congressional Budget Office recently submitted 115 options for reducing federal spending on health care. Option 55 would call for a 1% reduction to the Medicare update factor each year over the next 10 years.[10]

Opportunities in the Hospital Sector to Improve Efficiency

The March 2009 Medpac report is also instructive in that it points out the very large variation in hospital cost performance across the industry nationally. Overall Medicare margins are low, but Medpac observed that

[8] Again, both proposals are only for one year (FY 2010). The graph is intended to illustrate the waiver test impact if each proposal were continued into the following rate year.
[9] Medpac report to Congress, March 2009 pages 16-17
[10] Congressional Budget Office Report to the House and Senate Budget Committees, Budget Options Volume I – Health Care, December 2008

hospitals facing broad financial constraint from both public and private sector payers tend to have much lower costs than hospitals that tend to have high private payer margins and thus less broad based financial pressure. Their overall conclusion is that revenue levels and constrained revenue levels tend to drive cost performance of the industry. Given the wide variation in cost performance (depending upon the market conditions faced) there is considerable opportunity for hospitals generally to improve their operating efficiency.

This observation is consistent with HSCRC staff observation that hospitals that face more stringent and broad based constraint tend to reduce costs more effectively. When the HSCRC has been provided more restricted inflation updates, operating efficiency and cost performance do improve. When the HSCRC has been more generous in its update factors year-to-year, hospital cost spending increases. Similarly, hospitals who are placed on spenddowns (negotiated rate reduction arrangements) after having been identified as a "high cost hospital" on the HSCRC Reasonableness of Charges (ROC) analysis also tend to manage their costs more effectively as their annual revenue base is more tightly constrained.

This observation is strongly supported by actual year-to-year payment vs. cost experience in Maryland. **Table 7** and **Chart 3** show the year-to-year relationship between approved revenue increases and the resulting hospital expenditure growth over the period 1988 -2007. Most hospitals budget their expenses based on their expected income, just as most people do. If revenues are expected to go down, then they will reduce their expenditures, and if revenues are expected to increase then they will allow costs to increase accordingly. This can be seen in the following chart, which shows expenses and net patient revenue per EIPA tracking very closely for the period 1987 to 2007. The correlation coefficient between the expense and net patient revenue per EIPA is 0.999. This analysis strongly support Medpac's conclusion in the March 2009 Report to Congress noted above, that revenues drive costs. As pressure is placed on the revenue curve facing the hospital industry, the behavioral response has and will be to improve efficiency.

Table 7

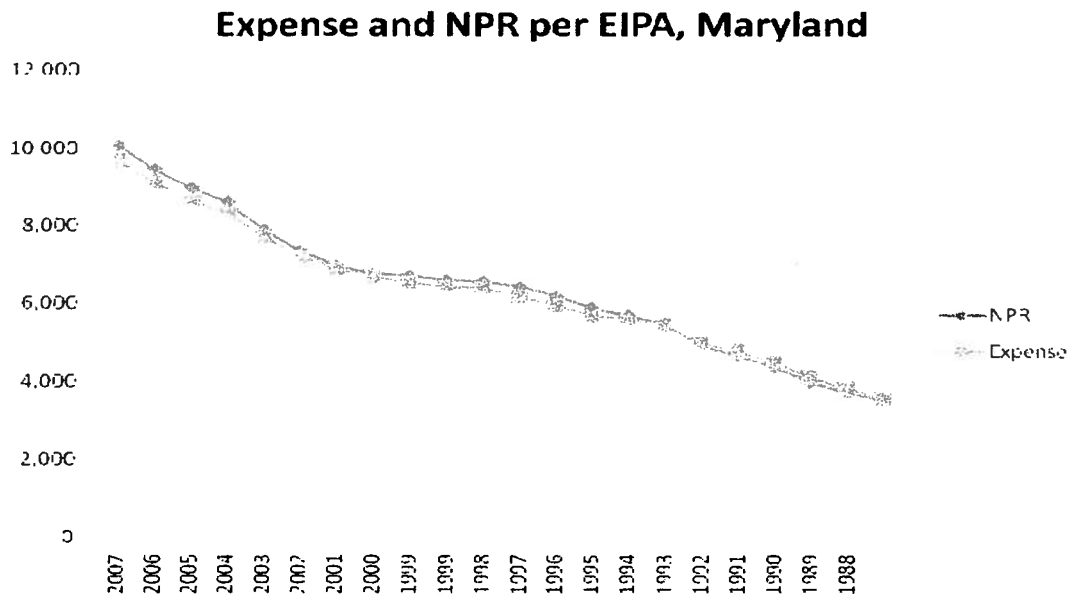
Payment Updates Drive Cost Performance (HSCRC 1988-2007)

	Net Rev/EIPA	Cost/EIPA
2007	6.33%	6.18%
2006	5.39%	5.39%
2005	4.21%	3.93%
2004	9.14%	7.57%
2003	7.13%	7.11%
2002	5.41%	4.56%
2001	3.09%	3.17%
2000	0.48%	1.70%
1999	1.97%	2.18%
1999	0.35%	0.34%
1998	2.08%	3.74%
1997	4.13%	3.65%
1996	5.09%	4.52%
1995	3.39%	1.63%
1994	4.06%	2.81%
1993	10.66%	9.61%
1992	6.05%	3.77%
1991	6.93%	6.86%
1990	9.44%	8.94%
1989	7.42%	7.44%
1988	5.59%	7.60%

Chart 3

Relationship of change in Revenue per EIPA

and resulting Change in Cost per EIPA (1988-2007)



Source: HSCRC annual filing 1988-2007

Role of Payment Policy in the Context of Current Economic Conditions and Access to Capital Considerations

Medpac also commented in the March report on the most appropriate role for payment policy in the context of deteriorating economic conditions. Medpac acknowledges that declines in investment income, increasing interest rates, and flattening volumes may contribute to declining financial results. However, they also note that if hospitals do a better job of controlling their costs in response to economic conditions (constraining wage and non-wage growth) these factors should offset conditions leading to increased costs. Medpac concludes that attempting to offset overall economic conditions through increased payments would not be appropriate because the implications of the decline in overall economic conditions for Medicare payment adequacy are not straightforward, may change in the short run, and may differ by sector. Additionally, Medpac concludes that current access to capital issues caused by the extraordinary conditions in national credit markets have little to do with the adequacy of Medicare payments and that payment policy is an ineffective mechanism to use to attempt to address access to capital issues in the current environment.

Lastly, the Medpac report strongly argues that rising health care costs in the US has serious negative impacts on the rest of our economy in the form of reduced international competitiveness of US firms, lower real wage growth, and other negative distributional effects such as increased cost-sharing for employees and reductions in coverage and corresponding increases in the number of uninsured.

Staff Proposed Update

Based on the factors noted, staff proposed to the Payment Work Group for discussion, an overall 1.27% update to hospital rates for FY 2010 (one-year update). Coupled with expected volume increases of 0.99%, this should result in a projected increase in payment levels of $292 million over FY 2009. **Table 8** provides a summary of the staff recommendation.

Table 8 – Staff Proposed Hospital Update for FY 2010

Staff Proposal	HSCRC
1 Market Basket	1.59%
2 Forecast Error	NA
3 Productivity Factor	-1.00%
4 Finanicial Condition Adjustment	NA
5 Subtotal	0.59%
6 "Projected Slippage 2010"	-0.10%
7 **Base Update**	**0.49%**
8 Volume Adjustment (1)	-0.22%
9 Case mix	1.00%
10 **Final Update**	**1.27%**
11 Blended I/P and O/P Update (2)	1.27%
12 Expected Volume growth 2010 (3)	0.99%
13 **Overall Projected Revenue Increase**	**2.26%**
14 Expected Overall Revenue Increase	$292 million

(1) Volume adjustment is based on a projection YE 2009 based on 9 months YTD data
(2) Staff recommended update is applied equally to inpatient and outpatient rates
(3) Expected volume increases for FY 2010 based on forecasted FY 2009 volume growth

While this magnitude of increase is considerably below FY 2009 rate updates, and may precipitate solvency concerns for a limited number of hospitals (the financial and liquidity challenges noted previously), the HSCRC has the flexibility to address these individual circumstances on a case by case basis, providing stop-gap rate relief for hospitals less able to respond.

Scaling and Quality Based Reimbursement (QBR) Proposal

ROC Scaling Proposal

In past years the HSCRC has included a so-called "scaling" adjustment based on each hospital's position on the Reasonableness of Charges (ROC) analysis (a peer-to-peer comparison of adjusted and standardized charge per case). Under the scaling recommendation, hospitals with adjusted charge per case below a normative standard were given a slightly higher update factor and those below the normative standard received a slightly lower update. The purpose of the scaling is to enable the rate system to systematically reward/penalize hospitals for relative levels of efficiency.

The discussion of scaling during the development of the ROC recommendation assumed the historical experience of the workgroup participants. That experience was that in a typical year the base update factor (not including case mix or other adjustments) would likely be between 4 and 5 percent. Under such a scenario the scaling proposal would have awarded the best performing hospitals on the ROC an addition 1-1.5 percent in rates above the update, and, conversely, the poor performing hospitals would have experienced a similar

reduction relative to the update factor. In other words, the scaling would have led to real adjustments to hospital rate structure to better align resources.

The current rate negotiations are not typical. Staff anticipates that the update factor approved by the Commission may well be quite low compared to recent experience. If the update factor is very low the relative impact of scaling, as proposed in the ROC recommendation, will also be very small. This runs counter to the intent of the scaling recommendation: to give a significant positive adjustment for hospital whose charges are relatively low, and to apply a negative adjustment to hospitals whose charges are relatively high. Therefore, to maintain the goal of the scaling recommendation we propose an alternative approach to scaling.

The proposed scaling approach in **Table 9** is based on the ROC positions of all Maryland hospital based on the methodology approved by the Commission in March. It assumes the following:

- An overall cumulative update factor of 0.5%.

- A scaling methodology based on the following:

    - The hospitals that are in the top and bottom deciles will have their update factor adjusted up or down by 0.5%. Thus, hospitals that are far above the peer group mean will have an update of 0.0%, and hospitals that are far below the peer group mean will receive an update of 1.0%.
    - Hospitals falling between the 75th and 90th percentile are continuously scaled plus or minus some portion of 0.5% depending on their relative position to their peer group mean.
    - Hospitals whose rates are set on a total patient revenue (TPR) basis receive the update factor with no scaling adjustment.
    - The adjustment for hospitals not subject to any positive or negative scaling is slightly greater than 0.5%. This is due to the fact that hospital who are being negatively scaled accounted for more revenue than those being positively scaled, thus to meet the cumulative 0.5% update target the standard update was slightly increased

Quality Based Reimbursement (QBR) Adjustment: The quality based reimbursement (QBR) adjustment is applied additively to the scaled update factor based on ROC position. The adjustment was arrived at as follows:

- 0.5% of rates is at risk for a quality based adjustment.

- The quality portion of each hospital adjustment was scaled based on the QBR methodology. The actual hospital scaled amounts (using a previous year's data) range from a low of 0.4203% to a high of 0.5731%.

- The QBR adjustment is each hospitals variance from 0.5%, or from -0.0759% to +0.0696% (again based on a previous year's worth of data).

Results of Scaling Proposal

It should be noted the staff's original draft recommendation for ROC scaling has been modified to cut off the impact of negative scaling at 0% to avoid providing any hospital with a negative update. When both ROC and

QBR scaling are applied two hospitals do receive negative adjustments (Chester River and Southern Maryland). This is because these two facilities are at the lower end of the ROC scaling (a position of a -0.5% adjustment bringing them to a 0% update) and perform poorly on the QBR scaling.

Table 9 – Impact of Staff Draft QBR and Scaling Proposal

Components of the Update Factor

HOSPITAL NAME	ROC SCALED UPDATE FACTOR	QUALITY BASED REIMBURSEMENT SCALED ALLOWANCE	TOTAL UPDATE FACTOR
Southern Maryland Hospital Center	0.000%	-0.063%	-0.063%
Chester River Hospital Center	0.000%	-0.021%	-0.021%
Memorial of Cumberland	0.000%	0.014%	0.014%
Atlantic General Hospital	0.000%	0.015%	0.015%
St. Joseph Medical Center	0.000%	0.021%	0.021%
Doctors Community Hospital	0.229%	-0.076%	0.153%
Harford Memorial Hospital	0.210%	0.018%	0.229%
Johns Hopkins Hospital	0.218%	0.011%	0.229%
Bon Secours Hospital	0.295%	-0.020%	0.275%
Union Memorial Hospital	0.313%	0.016%	0.329%
Washington Adventist Hospital	0.339%	0.012%	0.351%
Laurel Regional Hospital	0.538%	-0.052%	0.486%
Montgomery General Hospital	0.538%	-0.048%	0.490%
Prince Georges Hospital Center	0.538%	-0.046%	0.492%
Garrett County Memorial Hospital	0.500%	-0.002%	0.498%
Northwest Hospital Center	0.538%	-0.037%	0.501%
Johns Hopkins Bayview Medical Cente	0.538%	-0.031%	0.507%
Howard County General Hospital	0.538%	-0.027%	0.511%
Shady Grove Adventist Hospital	0.538%	-0.021%	0.517%
Good Samaritan Hospital	0.538%	-0.012%	0.526%
Braddock Hospital	0.538%	-0.009%	0.529%
Suburban Hospital	0.538%	-0.009%	0.529%
Civista Medical Center	0.581%	-0.045%	0.536%
University of Maryland Hospital	0.538%	0.000%	0.538%
James Lawrence Kernan Hospital	0.538%	0.000%	0.538%
Holy Cross Hospital	0.538%	0.006%	0.544%
Carroll Hospital Center	0.538%	0.007%	0.545%
Mercy Medical Center	0.538%	0.007%	0.545%
Franklin Square Hospital Center	0.538%	0.007%	0.545%
Peninsula Regional Medical Center	0.538%	0.012%	0.550%
Baltimore Washington Medical Center	0.538%	0.017%	0.555%
Upper Chesapeake Medical Center	0.538%	0.018%	0.556%
Sinai Hospital	0.538%	0.018%	0.556%
Anne Arundel Medical Center	0.538%	0.030%	0.568%
McCready Memorial Hospital	0.500%	0.070%	0.570%
St. Mary's Hospital	0.538%	0.051%	0.589%
GBMC	0.538%	0.056%	0.594%
St. Agnes Hospital	0.892%	-0.026%	0.866%
Washington County Hospital	0.940%	-0.043%	0.897%
Frederick Memorial Hospital	0.926%	-0.004%	0.922%
Maryland General Hospital	0.933%	0.012%	0.944%
Memorial Hospital at Easton	1.000%	-0.024%	0.976%
Calvert Memorial Hospital	1.000%	-0.006%	0.994%
Dorchester General Hospital	1.000%	0.000%	1.000%
Union of Cecil	1.000%	0.008%	1.008%
Fort Washington Medical Center	1.000%	0.025%	1.025%
Harbor Hospital Center	1.000%	0.045%	1.045%

Summary of Staff Recommendations

1-Update Factor

The final staff recommendation regarding the update factor for FY 2010 (one year only) is as follows;

a) A base update (applied to both inpatient Charge per Case, outpatient Charge per Visit and any additional outpatient unit rates), of 0.49% (derived from Global Insights market basket estimate of 1.59% for FY 2010 less a 1.0% productivity factor less a 0.1% adjustment for system slippage in FY 2010);

b) Application of the Commission previously approved 85% variable/15% fixed cost volume adjustment;

c) A maximum provision for case mix change of 1.0% (the lesser of actual or 1.0%);

2-Scaling Methodology

a) An overall cumulative update factor of 0.5%.

b) A scaling methodology based on the following:

1-The hospitals that are in the top and bottom deciles will have their update factor adjusted up or down by 0.5%. Thus, hospitals that are far above the peer group mean will have an update of 0.0%, and hospitals that are far below the peer group mean will receive an update of 1.0%.

2-Hospitals falling between the 75th and 90th percentile are continuously scaled plus or minus some portion of 0.5% depending on their relative position to their peer group mean.

3-Hospitals whose rates are set on a total patient revenue (TPR) basis receive the update factor with no scaling adjustment.

4-The adjustment for hospitals not subject to any positive or negative scaling is slightly greater than 0.5%. This is due to the fact that hospital who are being negatively scaled accounted for more revenue than those being positively scaled, thus to meet the cumulative 0.5% update target the standard update was slightly increased

c) The quality based reimbursement (QBR) adjustment is applied additively to the scaled update factor based on ROC position. The adjustment was arrived at as follows:

1-0.5% of rates is at risk for a quality based adjustment.

2-Based on results from a previous year of data - the quality portion of each hospital adjustment was scaled based on the QBR methodology. The actual hospital scaled amounts range from a low of 0.4203% to a high of 0.5731%.

3-The QBR adjustment is each hospitals variance from 0.5%, or from -0.0759% to +0.0696% (based on previous year's worth of data).

The Quality Based Reimbursement final recommendation is before the Commission at the May 13, 2009 meeting. This document discusses the methodology and data to be used in the development of the QBR scaling results. The above results are illustrative and anticipated to closely approximate the final QBR scaling result.

3-Other Provisions

The staff draft proposal also recommends the following:

a) Retention of the previously (current policy) Commission approved 15% volume adjustment (per the 2008 HSCRC approved policy);

b) Retention of the previously approved (current policy) 7% minimum Waiver Cushion Level (penetration of this level on an actual or projected basis will allow the Commission to take immediate action to restore the cushion to more acceptable levels – this is current Commission Policy);

c) Staff is not recommending the Commission adopt the payer recommendation to reduce the current financing discounts allowed by the HSCRC (this proposal has been discussed extensively by the HSCRC staff and members of the Payment Workgroup and the general consensus is to not adopt a change at this time).

Appendix I – Payer Proposals (Hospital proposal not yet received)

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May 6, 2009

Don Young, Chairman
Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, MD 21215

Robert Murray, Executive Director
Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, MD 21215

Re: Rate Year 2010 update

Dear Don and Bob:

This letter, written on behalf of CareFirst and Kaiser Permanente, addresses the staff recommendation distributed at the April 15 Commission meeting. Only three events of note regarding the update have occurred since the payers presented as a panel at that Commission meeting. First, the MHA panel presented following the payers; second, there was a meeting of the Payment Work Group on April 22; and third, CMS issued its proposed regulations regarding the inpatient prospective payment system (IPPS) for Federal Fiscal Year (FFY) 2010. These comments address these developments as well.

April 15 MHA panel Presentation

First, regarding the MHA presentation at the April 15 meeting, the payers take very strong exception to the analysis presented that compared hospital profit margins in 2013 under the payers' proposal to hospital profit margins in 2013 under the hospitals' proposal. The MHA analysis was based on the fully mistaken idea that the payers had proposed a 4-year freeze in the update factor. This could not have been further from the truth. We have proposed a one-year freeze. The one-year freeze has no implications for the update factor we will later propose for 2011, 2012 or 2013, and there is no basis for the MHA to model such a proposal – especially one that shows a financial disaster.

Second, the MHA model of the difference in operating profits for hospitals in 2009, given the different update factor recommendations of the payers and the hospitals was in complete logical disagreement with the MHA testimony on potential job loss. In particular, the difference in bottom line was, essentially, equal to the difference in the update factors. That would mean that the cost increases would be the same under either rate increase. Yet, the MHA testimony was that the payers' proposal would cause lots of job loss while the MHA proposal would protect jobs. This illogic should not be allowed

to go unnoticed. Further, the MHA testimony regarding job loss simply verifies the Staff, Payer, and MedPAC position that higher hospital revenue generates higher hospital costs. The way to achieve efficiencies is to limit hospital revenues – that is both the national and Maryland experience.

April 22 PWG meeting

This meeting was largely called to see if the two sides and staff could come to consensus and to provide input on the Staff's new scaling proposal. Both the hospitals and the payers agreed that the scaling proposal depended on the update factor. In particular, CareFirst and Kaiser Permanente believe the staff's scaling proposal represents an improvement to the Staff's recommendation, because the update is sufficient to allow for relatively significant scaling. The Staff's scaling proposal is not appropriate within the context of the payers' proposal of a freeze, in part because the hospitals that would get a 0.75% scaling decrease might simply not take their inflation adjustment and scaling would turn out to be revenue increasing not revenue neutral, as it is meant to be. The MHA proposal is so high that the staff's scaling proposal actually would reduce the amount of scaling from what the MHA proposed, so the staff's scaling proposal is not an improvement under that circumstance, either.

In addition, at the April 22 meeting, the hospitals indicated that they would reduce their proposed increase in revenue per case from 3.75% to 3.25% and would also accept the 85% variable cost assumption on volume, that the Commission already voted be applied in RY 2010; but only if the other sides showed a willingness to negotiate. The staff indicated its willingness to negotiate if the hospitals dramatically reduced their new proposal, but not now. The payers, essentially, agreed with the staff. Therefore, the following does not reflect any change in CareFirst or Kaiser Permanente's recommendation – which is full support of the payers' proposal.

Medicare Waiver Issue

There has been much discussion about the Medicare waiver and the historically low level shown on the last CMS waiver update. There is general agreement that the waiver margin will go up in the short run, due to a combination of technical corrections and national Medicare casemix increases in 2008 and 2009 (nationally, Medicare casemix fell in FFY 2007) that exceed the reduction for casemix allowed by Congress. There is, certainly, agreement between the payers and the staff that the waiver margin will be significantly and negatively impacted once the 2010 national data is available due to CMS' recouping of excess casemix change. The AHA has advised hospitals that the proposed Medicare update for 2010 is negative 0.5% due, largely, to the casemix take back. Further, at least the payers and the staff are in agreement that sometime, relatively soon, Congress will reduce the Medicare update to well below the market basket and on a semi-permanent basis. Thus, the Medicare waiver may be a binding constraint for future negotiation, but the payers believe it is not a binding constraint for this one-year decision and is not the reason that CareFirst and Kaiser Permanente support a one-year freeze.

Payers' Update Recommendation and Rational

The key to the freeze is to make hospital care in Maryland more affordable and to, once again, drive hospital costs and net patient revenue in Maryland below the national average. We are convinced that the way to reduce costs is to reduce revenue. As noted above, even the MHA's panel testimony supported that idea.

In the last two years for which AHA data are available (2005-7), cost per Equivalent Inpatient Admission (EIPA) in Maryland hospitals has increased from 3.65% below the national average to the national average. The Commission's target is to beat the national average by 3-6%. Clearly, changing course requires a huge change in the update, especially when the market basket itself has fallen dramatically in this economy. During that same period, Net Patient Revenue per EIPA went from 2.58% below the national average to 0.53% above the national average and Net Operating Revenue per EIPA went from 4.28% below the national average to 1% below the national average. We believe a one-year freeze sends the correct message to the industry; namely, that the Commission is serious about moving Maryland's hospital costs and net revenue per case significantly toward the target zone below the national average and that efficiencies need to be pursued. (We also believe that the past two years, 2008 and 2009, were at best a holding pattern relative to the nation.) As noted above, efficiencies are pursued when lower revenues are in the offing.

Three other parts of the payers' proposal warrant discussion. All three regard incentives to constrain volume growth. The most current AHA data (2007) show that nationally, both admissions and outpatient visits are falling. Maryland data show differently. The current national discussion emphasizes volume reductions associated with the recession – Maryland data does not. In addition, in an important recent article in the New England Journal of Medicine, *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*, Maryland was identified as the state with the highest Medicare readmission rate, topped only by D.C. The three parts of the payers' proposal that improve the incentives regarding volume are as follows:

- Casemix – the payers suggest that the casemix budget be the lesser of actual or 1.00% if volume increases and the lesser of actual and 1.25% if volume falls. The expectation is that real casemix will go up faster if volumes decrease – especially given the target of reducing one-day stays.

- Volume adjustment – the payers have asked that the Commission announce now that the variable cost adjustment associated with the RY 2010 volume change be reduced from 85% to 75%. This will be applied as part of the RY 2011 update, but the hospitals need to be told in advance. Incentives only work if the incentivee is aware of them. This, too, will increase the payment per case if volumes fall.

- Breadth of Comprehensive Charge Target (CCT) – the payers have proposed that the CCT be expanded significantly from covering about 50% of outpatient services to covering about 80% of outpatient services by adding radiology, radiation

therapy, chemotherapy and oncology services to the CCT on a hospital specific basis. The latest staff analysis shows that, while inpatient volume (exlusive of casemix) is up 0.23%, outpatient volume is up about 3%. The weighted average is a 1.2% increase, or 1.7% when funded case mix is considered. The CCT provides huge incentives to achieve outpatient efficiencies – and removes the pass-through for outpatient medical supplies and drugs for services covered under the CCT.

Finally, CareFirst and Kaiser Permanente are very supportive of the continuation of the Nurse Support Programs and of the achievements regarding access and financing of uncompensated care. Regarding UCC, it is important to note that the payers' proposal is very specific about the idea that the UCC/mark-up continues to be outside the update calculation.

Thank you for your consideration.

Yours truly,

Hal Cohen
Consultant

Cc: Greg Vasas
Debra Collins
Jessica Boutin
Jerry Schmith
Dennis Phelps
Ellen Englert
Andy Udom
Char Thompson
Steve Ports

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May 5, 2009

Donald A. Young, M.D., Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Dr. Young:

Coventry Healthcare, Inc. appreciates the opportunity to submit these comments egarding the hospital payment update for FY 2010. Coventry is a national managed health care ompany operating health plans, insurance companies, network rental services companies and /orkers' compensation service companies. Through its Commercial Business, Individual Consumer and Government Business, and Specialty Business divisions, Coventry provides a full ange of risk and fee-based managed care products and services to a broad cross section of individuals, employer and government-funded groups, government agencies, and other insurance carriers and plan administrators.

In addition to being home to our corporate headquarters, we are committed to the Maryland health insurance market. In Maryland, Coventry offers competitive health insurance plans to businesses, individuals and also partners with the state Medicaid program.

In light of the decision to limit the payment update to this upcoming rate year FY 2010, Coventry urges that the rates be kept at current levels. As a payor in both the commercial and the Medicaid markets, we feel it is prudent in these tough economic times to control costs as much as possible. Health care costs in the hospital setting can most effectively be kept in check by reducing the amount of revenues they receive. The tool for doing so is in the hospital rate etting update.

Maryland's Medicare waiver cushion is lower than it has been in some time which could only be exacerbated by the recession. Additionally, Medicare costs will need to be reduced as the deficit grows. All industries have been negatively impacted by this economic climate, ncluding the health insurance industry. The Maryland Hospital Association's ("MHA") proposed increase is incongruent with realities of the current economy. Businesses across the

State are seeing substantial drops in their revenues, and increasing costs are leading many to make the difficult decision to cut jobs. In this environment, the need to contain the ever-increasing costs of medical care is greater than it has been in decades.

This is not the time to raise hospital rates in Maryland. We strongly recommend a conservative approach to the payment update that keeps costs in control at a very difficult time in our nation's economy and ask for a rate freeze for FY2010.

Sincerely,

Brett S. Lininger

BSL:ddg
cc: Robert Murray, Executive Director

B0893134:23190-1

Impact of Hospital Creditworthiness on Access to Capital in Today's Debt Markets

Maryland Health Services Cost Review Commission

Baltimore, Maryland / May 13, 2009

KaufmanHall

Financial Strategies for Healthcare
5202 Old Orchard Road
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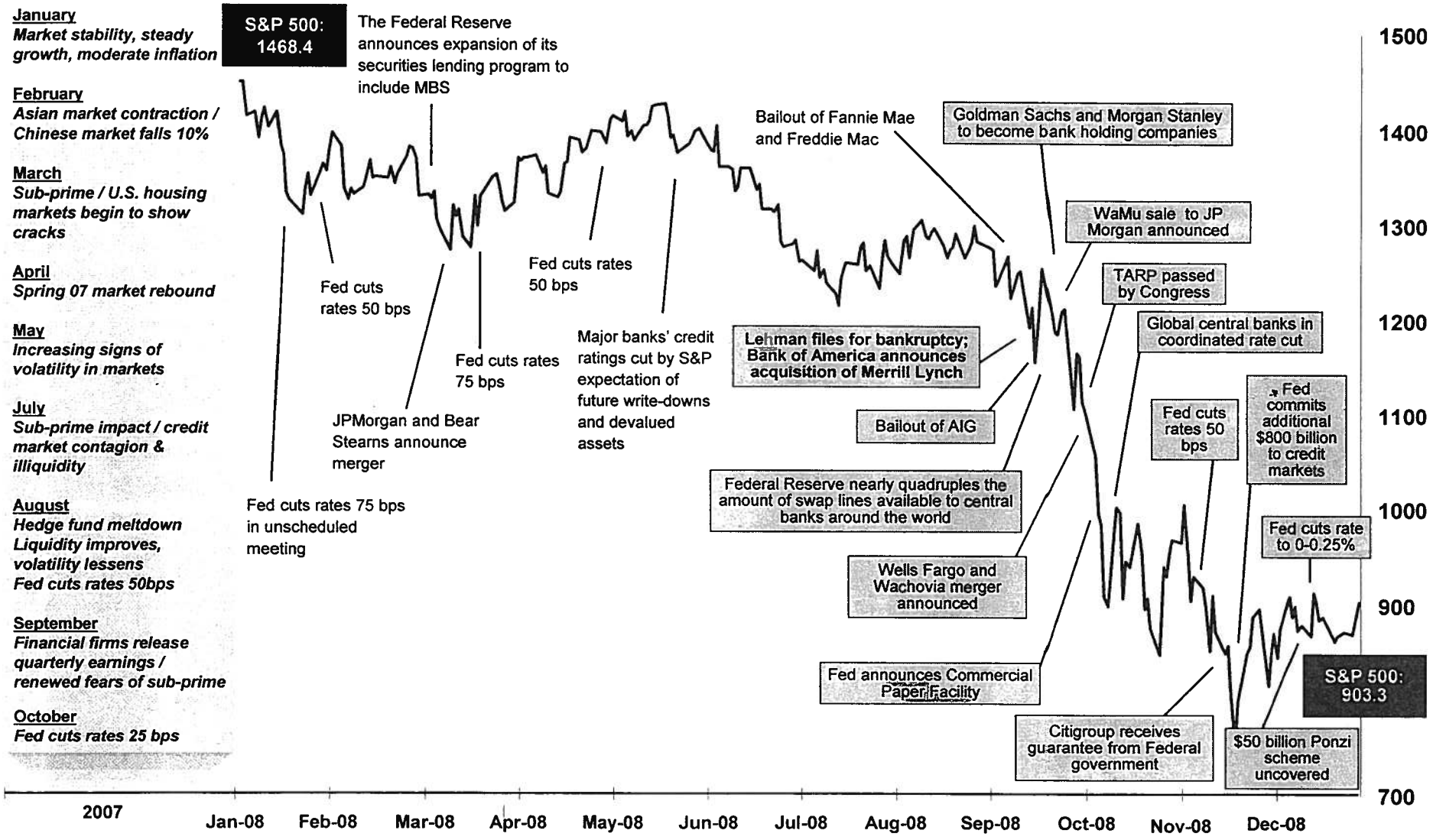
Today's Discussion

- The turmoil in the economy and the capital markets has had numerous impacts on the operations, funding requirements and capital access of hospitals
- The rating agencies, on behalf of investors, have identified these issues and have intensified their scrutiny
- The result is that access to capital for hospitals has fundamentally changed and a hospital's underlying creditworthiness is the foundation for capital access
- Beyond management and market dynamics, additional, imposed barriers to success have immediate impact on credit ratings and on investor willingness to fund debt
- Limitations on capital access have short and long-term implications for clinical quality and access

Source: Adapted from "Not-for-Profit Healthcare Sector Outlook Revised to Negative from Stable", November 2008.

An Unprecedented Chain of Events Has Occurred



Source: Investment Strategy Group, Federal Reserve, US Treasury, Bloomberg, Goldman Sachs.

For Hospitals, The Resulting List of Issues Is Long and Significant

Significantly Strained Operating Performance

- Decreased volume – especially outpatient services and surgery
- Bad debt/ charity care increases
- Increased interest expense
- Threatened state and federal cost containment efforts

Considerable Pressure on Liquidity

- Cash and investments losses
- Pension funding
- Swap mark-to-market and collateral posting
- Reduced operating cash flow

Competitive Capital Needs Continuing to Exceed Available Resources

- Physician alignment strategies: employment, joint ventures, etc.
- Aging facilities and increasingly costly technology
- IT requirements
- Market consolidation

Immediate Implications of Difficult Circumstances – Significant Pressure on Credit Ratings

Moody's Rating Trends

	Upgrades	Downgrades	Downgrade Ratio
Q1 2007	6	9	1.50
Q2 2007	9	12	1.33
Q3 2007	6	7	1.17
Q4 2007	10	13	1.30
Q1 2008	6	8	1.33
Q2 2008	10	10	1.00
Q3 2008	7	10	1.43
Q4 2008	**4**	**27**	**6.75**
Q1 2009	**5**	**19**	**3.80**

Key Rating Agency Concerns and Observations

- Access to capital is materially impaired and more costly
- Investment portfolio losses are adversely impacting cash flow and cash, resulting in weakened balance sheets and less financial flexibility
- Pension funding is a major financial concern for those with defined benefit programs (i.e., current market value ↓, discount rate ↓, earnings rate ↓)
- Physician employment strategies are increasingly more prevalent, but are creating more demands on finite liquidity
- Variable rate debt structures and swaps add considerable risk
- The economic recession is reducing utilization and adversely impacting payor mix and bad debt
- Widening credit gap will force more industry consolidation
- Capital plans will need to go back to the drawing board given all of the above
- Good management and governance now even more important

Source: Adapted from "Not-for-Profit Healthcare Sector Outlook Revised to Negative from Stable", November 2008.

What are the Implications for Hospitals' Access to Capital?

The Basic Capital Market Assumptions Are No Longer Valid

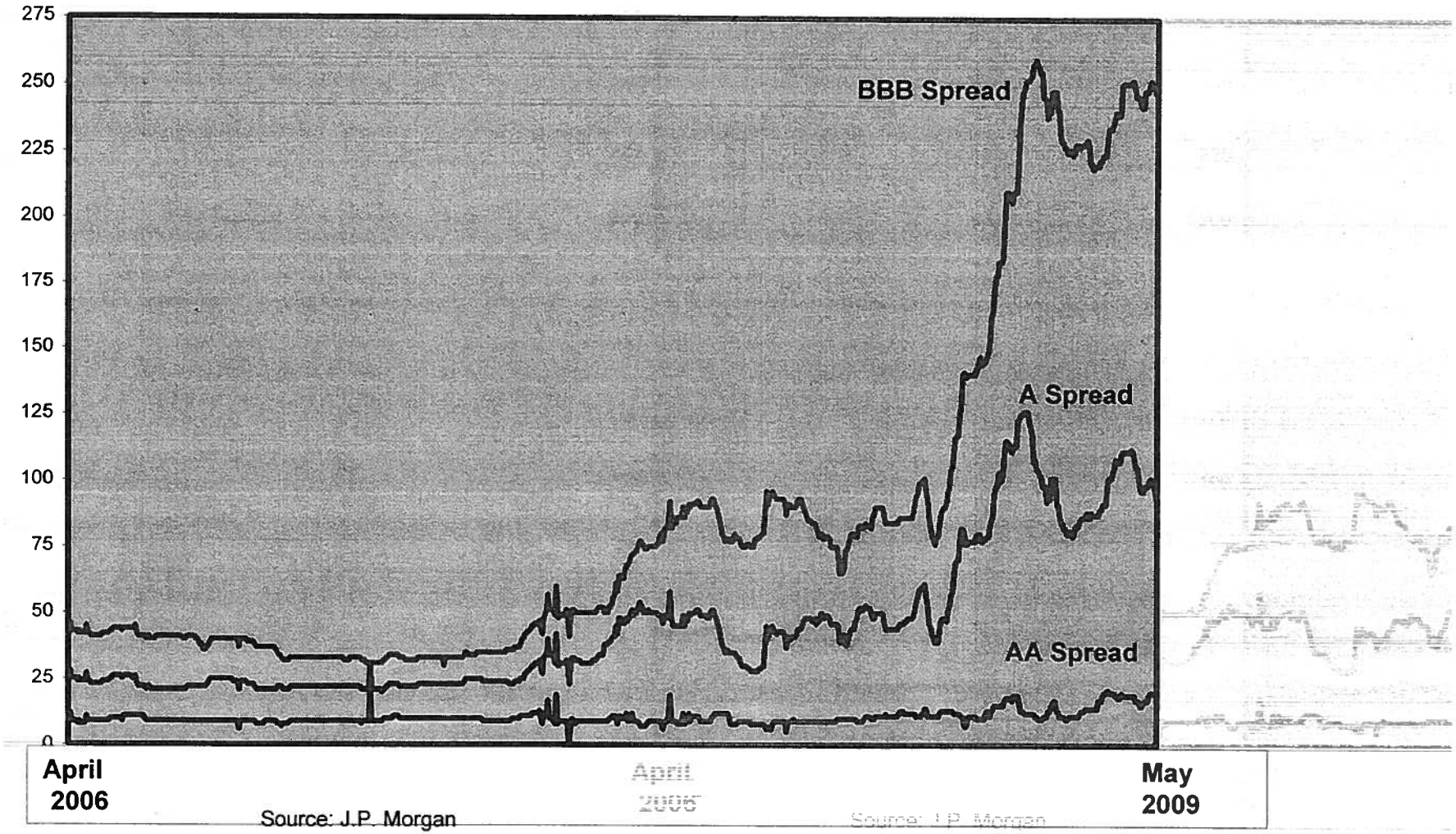
- ***Ready availability of funding for large strategic and facility plans***
  - Access to investor dollars is no longer a given
  - Cost, covenants, and security are not the only variables
- ***Credit enhancement to improve market access and lower cost***
  - Buyers are now focused on the underlying credit
  - Alternative products and structures with ostensible lower cost and full commitment have disappeared
- ***Cheap/ dependable capital access would be facilitated***
  - The capital marketplace is not yet fully functioning
  - Investment banks are no longer the ultimate backstop
- ***Cash retention/ creation would generate net investment returns***
  - The protective shield provided by cash and investments is severely damaged
  - Net positive returns to bolster operating "bumps in the road" and support higher credit ratings are no longer assured

Primary Capital Sources Are Limited and Less Palatable

- **Variable rate debt supported by commercial banks much more risky**
  - Increased interest rate volatility (0.20% to 8.00% in the last year)
  - Long-term bank survival and willingness to provide letters of credit is unclear
  - Costs, access, renewal, capacity, and terms are challenging
- **Fixed rate debt market is emerging, but still unpredictable**
  - Interest rates have mitigated, but are still well above recent historical levels
  - Investor appetite is very limited for credits below an "A" rating
- **Bank loans, private placements, or leasing vehicles exist, but only in small amounts with higher costs and shorter repayment terms**
- **Other sources of external capital are limited at best (e.g., grants, philanthropy, government tax support, etc.**

The Value of Creditworthiness is Now Real and Material

30-Year Credit Spreads to AAA MMD



Source: J.P. Morgan

Why are These Issues Relevant to the HSCRC?

For Hospitals, the Credit Rating Stakes Have Never Been Higher

- **A hospital's credit rating is the ultimate determinant of its capital access, regardless of credit enhancement**
- **The capital markets (investors and rating agencies) fully understand the implications of operational and balance sheet issues on hospitals**
- **Hospital management is expected to manage operational issues as a means to mitigate balance sheet risk and increased cost of capital**
- **To the extent that barriers to management exist (e.g., capability, community, or regulation) the implications are substantial and directly impact capital access**

Credit Review "Red Flags" for Not-for-Profit Hospitals

Operations Issues:

- Decline in total operating revenue (same-store basis)
- 30% decline in operating cash flow
- Days in account receivables rise to 100 and sustained at this level for two consecutive years
- Unexpected change in CFO
- Unusually high investment returns
- Pension liability funded at less than 80%
- Failure to deliver audit 6 months after the fiscal year end; tardy interim financial statements
- Qualified audit opinion

Source: Moody's U.S. Public Finance – Not-for-Profit Healthcare Rating Roadmap: Hospitals Under Stress, but Strong Management and Federal Stimulus May Mitigate Risks.

Credit Review "Red Flags" for Not-for-Profit Hospitals (continued)

Balance Sheet/Debt Issues:

- Technical default under bond covenants
- Covenant breach in bank documents
- Greater notional amount of swaps than debt
- Unexpected increase in debt (20% or more)
- Investment allocation with more than 10% in any one fund
- More than 70% of debt is variable rate (before swaps)
- Bank bonds with short payout or auction rate debt with high rates

Source: Moody's U.S. Public Finance – Not-for-Profit Healthcare Rating Roadmap: Hospitals Under Stress, but Strong Management and Federal Stimulus May Mitigate Risks.

Unique External Actions That Affect These Metrics Will Directly Limit Access to Capital

- **The rating agencies have already established a "negative outlook" for the hospital industry nationwide**
  - Investors appetite for hospital debt has been diminished
  - Higher rates and more protection are being demanded to gain investor dollars
- **Local/state/regional environments that create additional uncertainty will divert investor dollars**
  - Supply of hospital debt exceeds demand
  - Investors will move dollars to hospitals that provide the lowest risk and highest return
- **Investors that remain will demand higher interest rates**
  - Michigan as an example – interest rates .5% to 1% higher
  - Higher interest rates mean cash flow is paid to investors and not invested in improved quality and clinical programs and facilities

Maintaining Creditworthiness has Short and Long-Term Implications

- **In the short-term, reduced creditworthiness limits reasonable access to capital**
  - Downgrade to "BBB" from "A" would increase interest costs by over 1.5% ($15 million annually on $1 billion in debt)
  - Ongoing capital-based strategic and clinical initiatives may be stalled
  - New capital-based strategic and clinical initiatives must be deferred
  - Market consolidation will increase to provide capital access

- **In the longer term, higher cost and limited access will diminish hospitals' ability to provide access to needed services**
  - Limited investment in new sites of care and new, upgraded facilities
  - Constrained capacity, both inpatient and outpatient
  - Stagnation of growth
  - Further decreases in capital capacity and access

Conclusions

- The turmoil in the economy and the capital markets has created significant stress on hospital operations and ability to fund necessary initiatives
- A hospital's ability to maintain and improve its creditworthiness reduces this stress by enabling access to needed capital for initiatives to improve quality and access to clinical services
- Any actions taken that undermine hospital creditworthiness have direct implications relative to investor interest in funding needed capital for that hospital or market
- Current limitations to capital access not only have short term implications, but call into question the long-term viability of hospitals that are unable to fully invest in clinical quality and patient access

Source: Adapted from "Not-for-Profit Healthcare Sector Outlook Revised to Negative from Stable", November 2008.

Analysis of the Medicare Waiver Calculation

Current Medicare Waiver Status

Maryland Hospital Association

Most Recent CMS Waiver Cushion (March 2008 Waiver Letter)	6.61%
National Payment per Discharge Computation Issues:	
Inclusion of Medicare Secondary Payer Zero Pay Discharges	
Inclusion of Part A Exhausted Coverage Discharges / Other Zero Pay Discharges	
Unreconciled 2007/2008 Discharge Variance (MedPAR higher than Waiver Letter)	
Range of Impact = 2 - 3%	2.00%
Likely Current Waiver Cushion	8.61%

MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

MARTIN O'MALLEY
Governor
ANTHONY BROWN
Lieutenant Governor

T. ELOISE FOSTER
Secretary
DAVID C. ROMANS
Deputy Secretary

May 13, 2009

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

Dear Dr. Young:

I write in support of the staff's recommendation to limit the update factor for fiscal 2010 rates to 1.27%. Maryland, like the rest of the country continues to feel the impact of the national recession. Unemployment has increased, wages are stagnant and many families are struggling to pay their mortgages. Public and private sector entities are cutting costs and seeking greater efficiency. Many businesses and public entities are furloughing employees, implementing layoffs and reducing hours in an effort to cut costs and operate more efficiently.

Maryland State government has experienced a substantial revenue loss as the result of the economic downturn. Projected revenue for the current year and fiscal 2010 have been revised downward by more than $2 billion over the last five months. The State has responded to the loss of revenue by initiating more than $500 million in cost savings actions during the current fiscal year including employee furloughs and mid-year rate decreases for many Medicaid providers. In fiscal 2010, State general fund spending will decline by almost 4%. Many priority programs are flat funded or held to modest rates of growth in fiscal 2010. Medicaid rates for nursing homes, private duty nurses, dentists, and personal care providers are frozen for fiscal 2010, physician payment rates reduced, and rate increases for community-based providers capped at 0.9% rather than the 3.8% recommended by the rate commission responsible for studying their costs.

Adopting the staff recommendation will ask hospitals which have collectively earned healthy profits in recent years to tighten their belts in the same manner as Maryland families, State government, private companies, and other health care providers.

Compared to the proposal from the Maryland Hospital Association, the action will generate approximately $30 million of savings for the State and help to constrain the growth in health care costs allowing Maryland families to maintain health coverage during these trying economic times.

For these reasons, I urge adoption of the staff recommendation.

Sincerely,

T. Eloise Foster

T. Eloise Foster
Secretary

cc: Members of the Health Services Cost Review Commission

MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

Presentation to Health Services Cost Review Commission

T. Eloise Foster, Secretary
Department of Budget & Management
May 13, 2009

MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

Impact of Economic Downturn on Maryland

- The recession has dramatically reduced State revenues.
- Actual general fund revenues for FY 2009 and 2010 are expected to fall more than $2 billion short of the projections made in September 2008.
- Rising unemployment, stagnant wages, sharp declines in consumer spending, lower than expected corporate profits, and the dearth of new construction projects have contributed to the revenue write-downs.

State Government Has Curtailed Spending

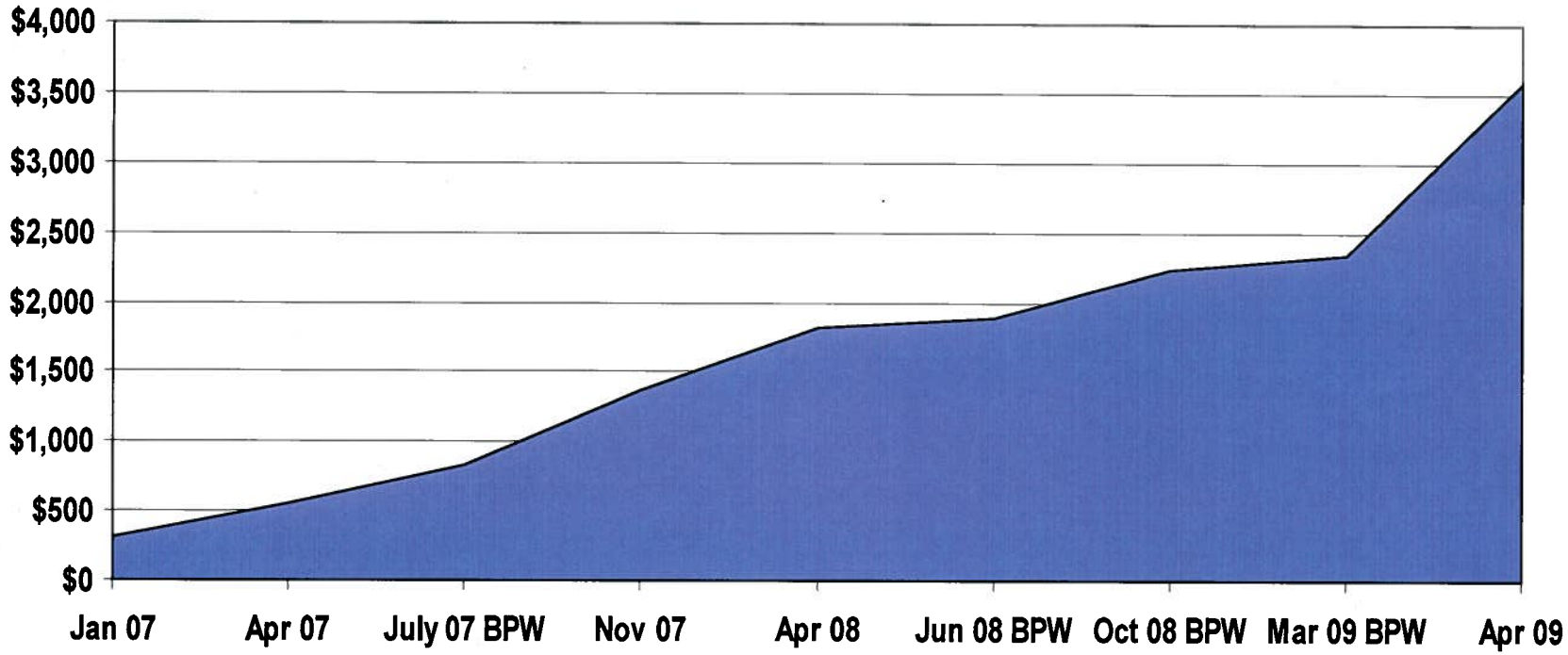
- Since the beginning of the O'Malley-Brown Administration, the State has made more than $3.5 billion in spending reductions including more than $500 million during FY 2009.

- During the same period, over 2,700 State government positions were eliminated.

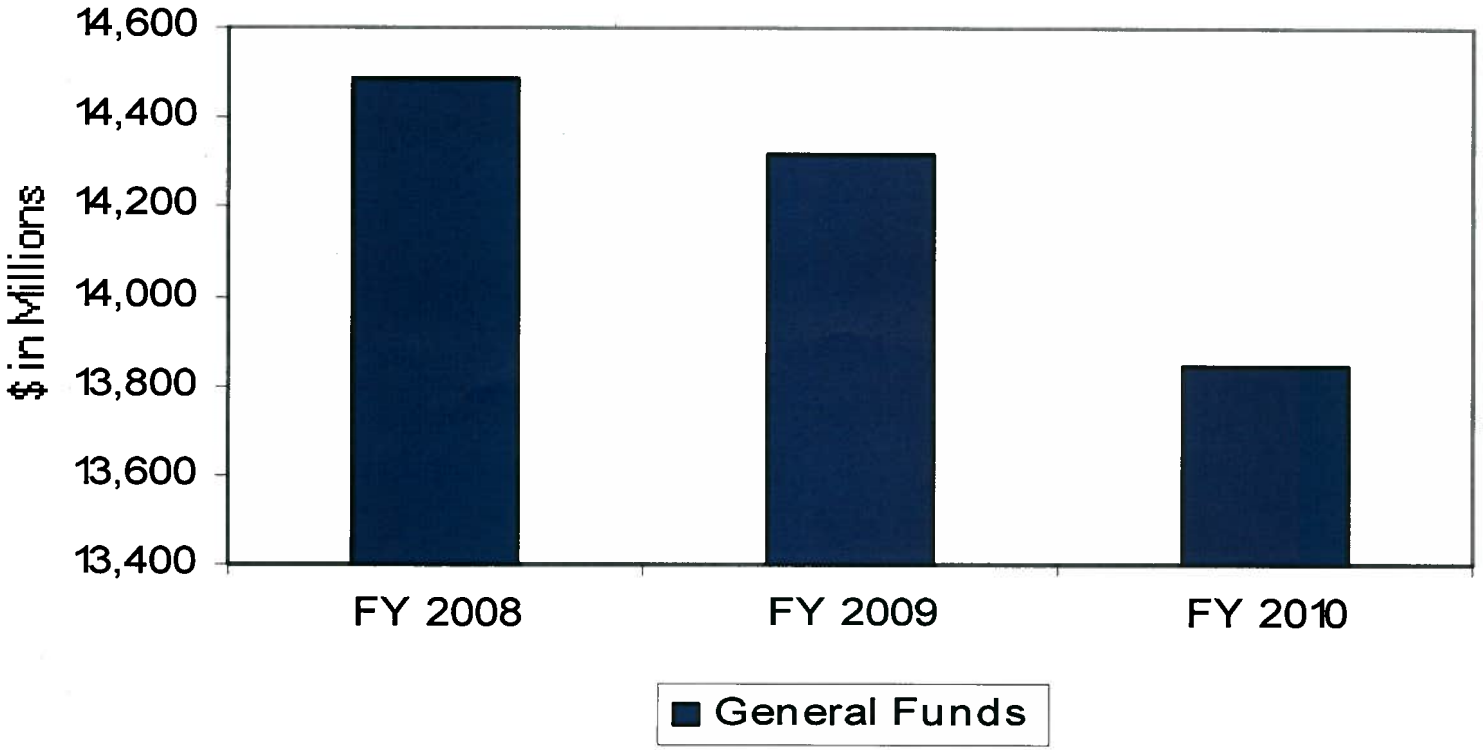
- The General Assembly approved a FY 2010 general fund budget that is almost 4% less than FY 2009 and nearly $700 million less than actual FY 2008 spending.

Cumulative Budget Reductions During O'Malley-Brown Administration

$ in Millions



Planned General Fund Spending Declines



Budget Reductions Impact All Segments of State Spending

- State Aid to local governments declines by 1% in FY 2010.
- State employees furloughed for 2-5 days in FY 2009. Employee salaries frozen for FY 2010.
- Three State health care facilities slated to close in FY 2009 or FY 2010.
- Most grant programs frozen at fiscal 2009 funding level.
- General Assembly enacted legislation waiving most mandated funding increases for FY 2011.

Impact of State Cost Containment on Provider Rates

- Due to fiscal constraints, the State has curtailed increases in payment rates for most providers of health care and human services.

- **FY 2010 Provider Rates**
  - Rate **freeze** for nursing homes and personal care providers.
  - Rate **freeze** for group homes serving children in foster care/juvenile justice system.
  - Physician rates **decrease** from 85% of Medicare to 82% of Medicare.
  - **0.9%** rate increase for most community-based providers that serve as alternative to institutional placements; far less than the 3.8% rate increase proposed by the commission that analyzes these costs.
  - 72% **reduction** in funding for tobacco prevention & cessation efforts.
  - Funding for local health departments **reduced** by 15% in FY 2009 and **frozen** for FY 2010.

MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

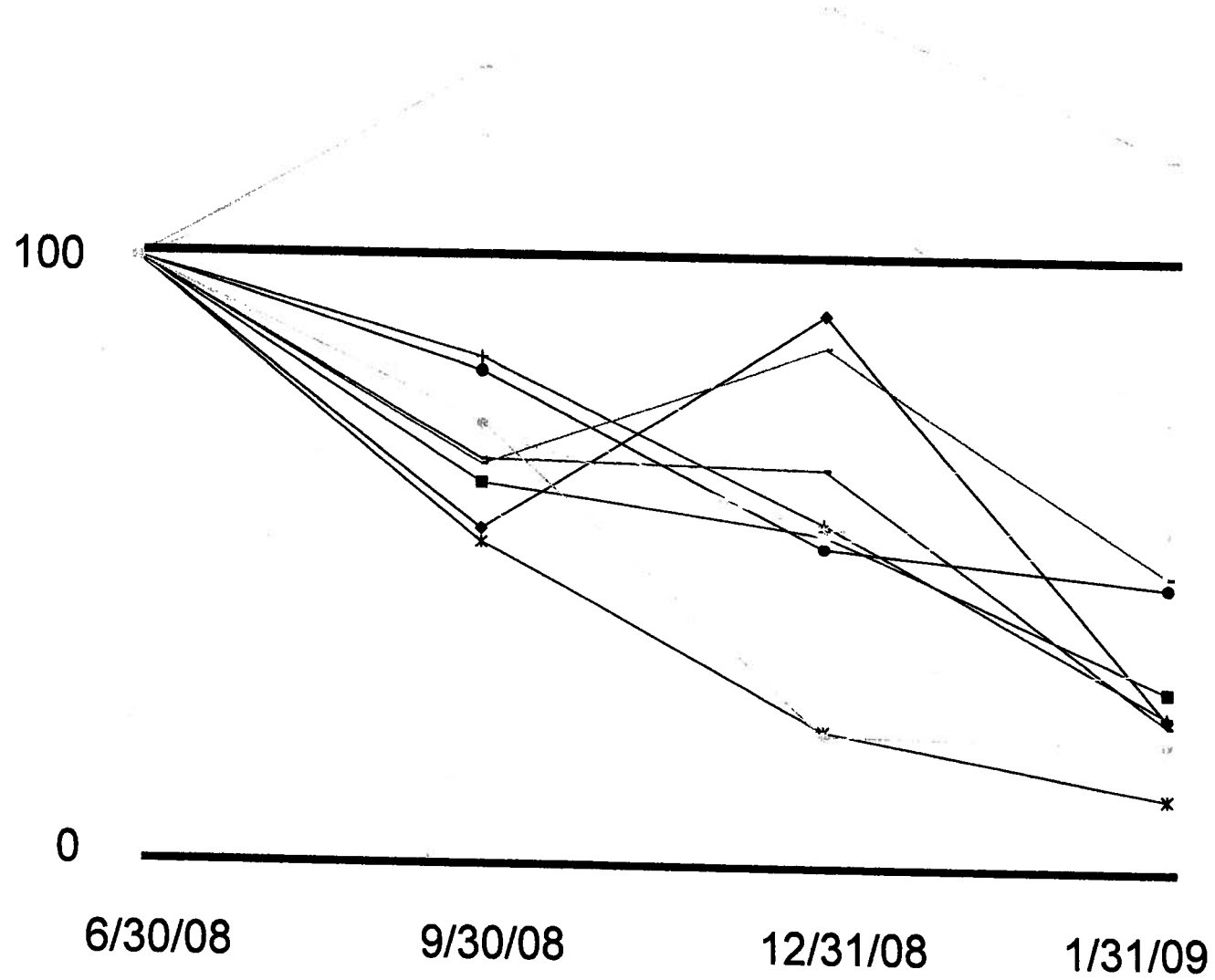
Hospital Rates

- DBM supports the HSCRC staff proposal to constrain the growth in hospital rates.
- Like the public sector, most private sector and non-profit entities have responded to the economic downturn by slashing costs and seeking efficiencies. Hospitals should be expected to participate in this process.
- Constraining the growth in hospital costs will help to maintain the affordability of heath insurance for both public and private sector purchasers.
- The staff proposal provides for a larger rate increase than almost any other provider serving Medicaid enrollees, and it will more than offset any savings expected from Medicaid Day Limits.
- The staff proposal will also **save State taxpayers about $30 million** compared to the proposal set forth by the hospitals.

Highlights of Second *Ad Hoc* Data Request For Month Ending January 31, 2009

Day Cash on Hand

6/30/08 = 100 Basis



Components of Total Income
Survey Respondents (N=40)

	RY 2007 6/3/0/07	RY 2008 6/30/08	QI RY 09 9/30/08 ($ MM)	QII RY 09 12/31/08	January-09 1/31/09
Operating Income	$250.4	$227.1	$68.2	$40.4	$15.5
Non-Operating Income	$353.9	($99.0)	($165.7)	($583.9)	$85.5
Total Income	$604.2	$128.1	($97.5)	($543.6)	$101.1

Appendix II – Breakdown of Unregulated Losses by Category FY 2008

Hosp. ID #	Hospital (in thousands)	Physicians Part B Revenue (Net)	Physicians Part B Expenses	Physicians Part B Profit/ Loss	Freestanding Clinic Revenue	Freestanding Clinic Expenses	Freestanding Clinic Profit/ Loss	Code	Phy Asst(PA), Home Health(HH) Amb/Surg(AMS), Skilled Nursing(SNF) Revenue	Phy Asst(PA), Home Health(HH) Amb/Surg(AMS), Skilled Nursing(SNF) Expenses	Phy Asst(PA), Home Health(HH) Amb/Surg(AMS), Skilled Nursing(SNF) Profit/ Loss	All Others Unregulated Revenue	All Others Unregulated Expenses	All Others Unregulated Profit/ Loss
1	Washington Co.	$22,389.0	$23,959.3	($1,570.3)	$3,261.5	$2,861.3	$400.2	HH	$3,868.0	$3,760.2	$107.8	$2,017.7	$2,714.9	($697.2)
2	University of Md(Note)			$0.0	$11,828.0	$18,260.9	($6,432.9)	CRNA	$1,250.3	$5,380.5	($4,130.2)	$27,683.5	$31,300.6	($3,617.1)
3	Prince George's	$4,911.1	$16,797.7	($11,886.6)			$0.0	SNF	$4,399.6	$6,631.6	($2,232.0)	$6,180.9	$7,442.1	($1,261.2)
4	Holy Cross	$0.0	$5,993.7	($5,993.7)	$1,643.6	$1,741.6	($98.0)	HH	$2,339.9	$3,401.9	($1,062.0)	$20,492.3	$24,789.8	($4,297.5)
5	Frederick	$0.0	$5,144.7	($5,144.7)	$11,187.4	$13,339.6	($2,152.2)	HH/SNF	$13,624.4	$14,317.5	($693.1)	$30,462.7	$31,202.9	($740.2)
6	Harford Memorial**			$0.0			$0.0	SNF	$1,933.5	$3,396.1	($1,462.6)	($1,933.5)	($3,396.1)	$1,462.6
7	St. Joseph	$9,533.1	$21,675.0	($12,141.9)			$0.0	Community	$545.1	$1,899.9	($1,354.8)	$12,221.4	$17,060.7	($4,839.3)
8	Mercy	$7,661.1	$8,845.3	($1,184.2)	$5,922.5	$5,238.6	$683.9	N/A			$0.0	$1,918.0	$3,181.2	($1,263.2)
9	JHH	$0.0	$1,065.0	($1,065.0)	$7,269.5	$6,994.3	$275.2	**MCO**	$0.0	$0.0	$0.0	$91,330.4	$86,584.9	$4,745.5
10	Dorchester	($328.0)	$130.8	($458.8)	$1,576.1	$1,389.2	$186.9	N/A			$0.0	$313.8	$1,296.9	($983.1)
11	St Agnes	$26,352.8	$44,135.5	($17,782.7)	$413.2	$493.6	($80.4)	HH	$1,204.3	$1,142.8	$61.5	$14,242.2	$13,904.0	$338.2
12	Sinai	$35,901.5	$71,408.8	($35,507.3)			$0.0	N/A			$0.0	$13,414.0	$16,772.9	($3,358.9)
13	Bon Secours	$618.5	$13,856.8	($13,238.3)	$7,655.1	$10,106.5	($2,451.4)	RDL	$4,039.3	$5,815.0	($1,775.7)	$1,061.9	$1,056.6	$5.3
15	Franklin Square	$23,110.9	$28,111.1	($5,000.2)	$11,884.9	$17,740.7	($5,855.8)	PA	$0.0	$3,992.8	($3,992.8)	$4,934.8	$4,592.9	$341.9
16	Washington Adventist**	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
17	Garrett	$1,583.8	$1,588.5	($4.7)			$0.0	SNF/CRNA	$1,465.9	$2,652.6	($1,186.7)	$2,422.7	$1,370.9	$1,051.8
18	Montgomery General	$0.0	$2,643.3	($2,643.3)			$0.0	PA	$0.0	$828.0	($828.0)	$979.4	$1,087.7	($108.3)
19	Peninsula Regional	$4,911.3	$10,110.0	($5,198.7)	$5,677.7	$8,857.3	($3,179.6)	SNF	$3,879.6	$4,414.9	($535.3)	$5,387.0	$7,285.4	($1,898.4)
22	Suburban	$0.0	$287.3	($287.3)			$0.0	N/A			$0.0	$24,545.1	$22,901.0	$1,644.1
23	Anne Arundel	$5,805.1	$13,310.2	($7,505.1)	$8,246.4	$9,396.5	($1,150.1)	Community	$520.0	$2,547.7	($2,027.7)	$9,572.6	$8,976.5	$596.1
24	Union Mem	$18,673.7	$35,012.5	($16,338.8)			$0.0	N/A			$0.0	$16,824.8	$16,131.2	$693.7
25	Cumberland	$2,392.6	$2,921.4	($528.8)	$5,609.8	$3,400.1	$2,209.7	HH	$4,158.9	$6,083.4	($1,924.5)	$4,551.5	$3,810.2	$741.3
27	Braddock	$0.0	$3,107.0	($3,107.0)	$2,636.6	$6,728.0	($4,091.4)	SNF	$6,384.9	$5,517.6	$867.3	$5,678.5	$5,453.9	$224.6
28	St. Mary's	$1,776.8	$3,783.7	($2,006.9)	$111.8	$853.6	($741.8)	HH	$0.6	$31.3	($30.7)	$5,532.3	$5,110.8	$421.5
29	JHBMC	$752.9	$2,917.4	($2,164.5)	$0.0	$0.0	$0.0	SNF	$8,127.8	$11,209.8	($3,082.0)	$48,918.2	$48,714.5	$203.7
30	Chester River	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
32	Union Hospital	$4,429.2	$6,720.3	($2,291.1)	$330.0	$373.5	($43.5)	N/A			$0.0	$3,172.8	$3,192.5	($19.7)
33	Carroll	$1,516.6	$6,838.5	($5,321.9)	$0.0	$0.0	$0.0	AMS	$4,104.7	$5,212.0	($1,107.3)	$51,830.1	$50,912.8	$917.3
34	Harbor	$3,798.9	$6,400.2	($2,601.3)	$9,588.2	$11,034.4	($1,446.2)	N/A			$0.0	$10,158.6	$5,726.9	$4,431.8
35	Civista	$137.1	$32.3	$104.8			$0.0	N/A	$0.0	$0.0	$0.0	$1,134.3	$1,524.0	($389.7)
37	Easton	$0.0	$121.6	($121.6)	$2,587.3	$5,172.8	($2,585.5)	SNF	$0.0	$66.9	($66.9)	$11,111.7	$7,159.3	$3,952.4
38	Maryland General	($16.4)	$9,804.3	($9 820.7)	$155.4	$4,603.3	($4,447.9)	N/A			$0.0	$1,711.9	$1,420.8	$291.1
39	Calvert	$142.6	$1,116.7	($974.1)	$2,295.6	$2,549.2	($253.6)	SNF	$1,567.5	$4,063.6	($2,496.1)	$9,349.7	$10,501.6	($1,151.9)
40	Northwest	$4,136.7	$8,497.0	($4,360.3)	$0.0	$0.0	$0.0	SNF	$3,970.0	$5,595.9	($1,625.9)	$0.0	$308.3	($308.3)
43	Baltimore/Washington	$7,874.1	$10,944.6	($3,070.5)	$0.0	$0.0	$0.0	N/A	$0.0	$0.0	$0.0	$2,095.4	$1,076.1	$1,019.3
44	GBMC	$30,752.6	$43,970.1	($13 217.5)	$99.2	$850.3	($751.1)	SNF	$3,951.2	$4,680.8	($729.6)	$9,151.8	$7,376.4	$1,775.4
45	McCready	$1,231.9	$1,689.9	($458.0)			$0.0	SNF/CRNA	$295.9	$194.6	$101.3	$8.9	$276.8	($267.9)
48	Howard	$0.0	$112.9	($112.9)			$0.0	N/A			$0.0	$11,392.3	$15,551.1	($4,158.8)
49	Upper Chesapeake	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
51	Doctor's	$1,395.0	$1,970.1	($575.1)			$0.0	N/A			$0.0	$8,684.4	$7,059.5	$1,624.9
54	So. Maryland**	$0.0	$0.0	$0.0			$0.0	SNF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
55	Laurel	$1,004.8	$6,055.1	($5,050.3)			$0.0	N/A			$0.0	$222.5	$228.1	($5.6)
60	Ft Washington**	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
61	Atlantic General	$6,586.7	$12,029.7	($5,443.0)	$0.0	$0.0	$0.0	N/A			$0.0	$1,177.8	$1,351.4	($173.6)
2001	Kernan			$0.0	$1,783.1	$2,793.0	($1,009.9)	N/A			$0.0	$320.5	$888.1	($567.6)
2004	Good Sam	$16,768.7	$23,193.6	($6 424.9)	$0.0	$0 0	$0.0	SNF	$5,466.8	$6,127.5	($660.7)	$18,520.0	$20,155.1	($1,635.1)
5050	Shady Grove **	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
	All Acute Hospitals	$245,804.7	$456,301.9	($210,497.2)	$101,762.9	$134,778.3	($33,015.4)		$77,098.2	$108,964.9	($31,866.7)	$488,794.9	$494,055.1	($5,260.2)
	Operating Margin			-85.64%			-32.44%				-41.33%			-1.08%
	Note: Includes													
8994	Cancer			$0.0	$5,353.8	$4,079.0	$1,274.8	CRNA	$1,250.3	$5,380.5	($4,130.2)	($1,250.3)	($4,061.0)	$2,810.7
8992	Meims			$0.0			$0.0	N/A			$0.0	$1,250.3	$5,380.5	($4,130.2)
2	University Hos	$0.0	$0.0	$0.0	$6,474.2	$14,181.9	($7,707.7)	N/A	$0.0	$0.0	$0.0	$27,683.5	$29,981.1	($ 6)

Appendix III - Breakdown of Non-Operating Losses FY YTD 2009 (through January)

Non-Operating Income (Losses)

July 2008 through December 2008

		Realized Gain (Loss) on Investment	Realized Gain (Loss) on Swap	Unrealized Gain (Loss) on Investment	Mark to Market Swap Value	Other	Total	Reported
1	WASHINGTON COUNTY	($599,690)	$0	($6,233,754)	$0	($120,900)	($6,954,344)	($6,994,143)
2	UNIVERSITY OF MARYLAND	($13,194,000)		($36,822,000)	($128,743,000)	($9,553,000)	($188,312,000)	($188,312,000)
3	PRINCE GEORGE	$82,670				$13,325,391	$13,408,061	$14,783,833
4	HOLY CROSS	($3,512,000)		($5,273,000)	($13,557,000)		($22,342,000)	($22,341,090)
5	FREDERICK MEMORIAL			($11,084,000)	($12,304,000)	($2,285,000)	($25,673,000)	($25,674,201)
6	HARFORD MEMORIAL						$0	($12,628,672)
7	ST JOSEPH	($3,790,000)					($3,790,000)	($7,906,612)
8	MERCY	($2,472,000)	$0	($12,399,000)	($46,427,000)	($1,909,600)	($63,207,600)	($63,204,000)
9	JOHNS HOPKINS						$0	$9,573,702
10	DORCHESTER GENERAL	$142,800		$162,677		($528,223)	($222,746)	($52,214)
11	ST AGNES	$0	$0	($43,959,300)	$0	($624,916)	($44,584,216)	($44,584,216)
12	SINAI	$519,000		($9,089,000)		($835,000)	($9,405,000)	($8,195,652)
13	BON SECOURS						$0	($2,150,107)
15	FRANKLIN SQUARE	($32,932)		($98,597)		($40,952)	($172,481)	($44,930)
16	WASHINGTON ADVENTIST						$0	$516,509
17	GARRETT COUNTY					$124,176	$124,176	$124,177
18	MONTGOMERY GENERAL					($3,832,796)	($3,832,796)	($3,832,795)
19	PENINSULA GENERAL				($9,769,674)	($2,466,297)	($12,235,971)	($12,235,971)
22	SUBURBAN				($525,616)	($526,378)	($1,051,994)	($1,051,994)
23	ANNE ARUNDEL	$0	$0	($44,228,415)	($61,067,009)	$4,476,087	($100,819,337)	($100,819,337)
24	UNION MEMORIAL	($35,058)		($9,952,404)		$503,477	($9,483,985)	($4,466,074)
25	CUMBERLAND MEMORIAL			$181,344		$276,011	$457,355	$457,357
27	BRADDOCK			($7,828)		$717,112	$709,284	$709,284
28	ST MARY'S					$760,699	$760,699	$759,950
29	JOHNS HOPKINS BAYVIEW			($1,791,000)	($12,357,000)		($14,148,000)	$0
30	CHESTER RIVER	($725,000)				$38,000	($687,000)	($686,751)
32	UNION OF CECIL COUNTY					$1,138,759	$1,138,759	$1,119,998
33	CARROLL COUNTY					($15,491,803)	($15,491,803)	($15,491,803)
34	HARBOR HOSPITAL	($7,854)		($28,364)		$60,051	$23,833	$315,581
35	CIVISTA						$0	$37,708
37	EASTON MEMORIAL						$0	($11,612,847)
38	MARYLAND GENERAL	$259,000		($2,897,000)		($5,292,000)	($7,930,000)	($7,929,725)
3	CALVERT MEMORIAL	$163,003					$163,003	$163,003
40	NORTHWEST	$969,000		($13,619,000)		($275,000)	($12,925,000)	($12,925,114)
43	BALTIMORE/WASHINGTON	$784,000		($9,503,000)		($4,515,000)	($13,234,000)	($12,395,418)
44	GBMC	($3,856,675)		($83,126)		$786,728	($3,153,073)	($3,153,073)
45	MCCREADY					$85,521	$85,521	$85,521
48	HOWARD COUNTY			($777,200)	($12,959,058)		($13,736,258)	($12,852,007)
49	UPPER CHESAPEAKE						$0	$8,674,564
51	DOCTORS COMMUNITY	($10,067,000)		$2,865,000	($27,829,000)		($35,031,000)	($36,794,567)
54	SOUTHERN MARYLAND						$0	$389,703
55	LAUREL REGIONAL						$0	$288,091
60	FT WASHINGTON					$28,079	$28,079	$28,079
61	ATLANTIC GENERAL					$92,550	$92,550	$15,997
2001	KERNAN	($342,000)		($1,638,000)		($1,444,000)	($3,424,000)	($3,424,000)
2004	GOOD SAMARITAN					($16,664)	($16,664)	$630,600
5050	SHADY GROVE						$0	$1,337,078
8992	UNIVERSITY STC						$0	$991,000
8994	UNIVERSITY ONC						$0	$406,000
	Statewide	($35,714,736)	$0	($206,274,967)	($325,538,357)	($27,344,888)	($594,872,948)	($580,351,578)
3	PRINCE GEORGE	$82,670	$0	$0	$0	$13,325,391	$13,408,061	$14,783,833
13	BON SECOURS	$0	$0	$0	$0	$0	$0	($2,150,107)
55	LAUREL REGIONAL	$0	$0	$0	$0	$0	$0	$288,091
	Problem Hospitals	$82,670	$0	$0	$0	$13,325,391	$13,408,061	$12,921,817
	All Other Hospitals	($35,797,406)	$0	($206,274,967)	($325,538,357)	($40,670,279)	($608,281,009)	($593,273,395)

Consolidated Financial Statements

Acute Hospitals

ACUTE HOSPITALS - INDUSTRY TOTALS FROM July 2008-March 2009

Line Code	Category	Year To Date "Month" Regulated	Unregulated	Total
A	Inpatient Revenues	6,644,360,239	139,858,947	6,784,219,186
B	Outpatient Revenues	3,064,838,783	746,746,414	3,811,585,197
C	Gross Patient Revenues, (A+B)	9,709,199,022	886,605,361	10,595,804,383
D	Inpatient Charity Care	141,933,608	254,581	142,188,189
D1	Inpatient Bad Debts	313,501,407	2,065,346	315,566,753
E	Outpatient Charity Care	67,911,101	4,313,743	72,224,844
E1	Outpatient Bad Debts	231,567,018	13,184,932	244,751,950
F	Inpatient Hscrc Approved Discounts & Differentials	325,683,176	0	325,683,176
F1	Inpatient Denials	83,939,477	2,331,384	86,270,861
F2	Inpatient Admin., Courtesy, Policy, & Other Disc. & Adj.	38,876,426	98,266,934	137,143,360
F3	Outpatient Hscrc Approved Discounts & Differentials	136,443,133	0	136,443,133
F4	Outpatient Denials	32,996,674	5,028,116	38,024,790
F5	Outpatient Admin.,Courtesy,Policy & Other Disc.& Adj.	22,698,826	318,309,459	341,008,285
F6	Total Disc.,Diffs, Denials & Adj. (F+F1+F2+F3+F4+F5)	640,637,712	423,935,893	1,064,573,605
G	Deductions From Revenue, (D+D1+E+E1+F6)	1,395,550,846	443,754,495	1,839,305,341
H	Net Patient Revenues, (C-G)	8,313,648,176	442,850,866	8,756,499,042
I	Other Operating Revenues	111,914,332	201,745,320	313,659,652
J	Net Operating Revenues, (H+I)	8,425,562,508	644,596,186	9,070,158,694
	OPERATING EXPENSES:			
K	Salaries & Wages	3,254,876,905	378,341,092	3,633,217,997
L	Employee Benefits	714,407,049	65,772,447	780,179,496
M	Other Operating Expenses	3,555,660,284	296,498,722	3,852,159,006
N	Oper Exp (Excluding Depr & Int), (K+L+M)	7,524,944,238	740,612,261	8,265,556,499
O	Interest	145,878,728	958,789	146,837,517
P	Depreciation & Amortization	429,993,193	15,642,706	445,635,899
Q	Total Operating Expense, (N+O+P)	8,100,816,159	757,213,756	8,858,029,915
R	Excess(Def) Opr Revenues Over Exp, (J - Q)	324,746,349	(112,617,570)	212,128,779
S	Nonoperating Revenues	0	(465,843,836)	(465,843,836)
T	Nonoperating Expenses	0	73,767,765	73,767,765
U	Excess (Deficit) Revenue Over Expenses (R+S-T)	324,746,349	(652,229,171)	(327,482,822)

Calculations:			Total Admissions	522,860
REGULATED			EIPA	816,619
Gross Patient Revenues	9,709,199,022			
Deductions	1,395,550,846			
Net Patient Revenue	8,313,648,176			
Other Operating Revenue	111,914,332			
Net Operating Revenue	8,425,562,508		Reg Net Operating Revenue P/EIPA	10,317.62
Total Operating Expense	8,100,816,159			
Net Regulated Operating Profits	324,746,349		Reg Net Op Profit/Reg Net Patient Revenue	3.91%
Unregulated				
Gross Patient Revenues	886,605,361			
Deductions	443,754,495			
Net Patient Revenue	442,850,866			
Other Operating Revenue	201,745,320			
Net Operating Revenue	644,596,186			
Total Operating Expenses	757,213,756			
Net Unregulated Operating Profits	(112,617,570)		Unreg Op Profit/Unreg Net Patient Revenue	-25.43%
Totals				
Non Operating Revenue	(465,843,836)			
Non Operating Expenses	73,767,765			
Total Non Operating Profit	(539,611,601)		Non Op Profit/Non Op Revenue	115.84%
Net Patient Revenue	8,756,499,042			
Total Net Operating Revenue	9,070,158,694		Total Net Op Rev/EIPA	11,106.97
Total Operating Profits	212,128,779		Total Operating Profit/Total Net Operating Rev	2.34%
Total Non Operating Profits	(539,611,601)			
Total Profits	(327,482,822)		Total Profits/(Net Op and Non Op Revenue)	-3.81%

Consolidated by Hospital 07/2008 - 03/2009

5/8/2009

Consolidated Financial Statements — **ACUTE HOSPITALS - INDUSTRY TOTALS FROM July 2007 - March 2008**

Acute Hospitals

Code	Category	Year To Date "Month" Regulated	Unregulated	Total
A	Inpatient Revenues	6,310,481,344	161,017,180	6,471,498,524
B	Outpatient Revenues	2,816,723,509	710,641,305	3,527,364,814
C	Gross Patient Revenues, (A+B)	9,127,172,831	871,657,067	9,998,829,898
D	Inpatient Charity Care	144,173,578	193,073	144,366,651
D1	Inpatient Bad Debts	325,198,780	1,601,027	326,799,807
E	Outpatient Charity Care	57,240,847	4,181,184	61,422,031
E1	Outpatient Bad Debts	218,714,838	14,148,378	232,863,216
F	Inpatient Hscrc Approved Discounts & Differentials	306,099,662	0	306,099,662
F1	Inpatient Denials	75,396,556	1,466,332	76,862,888
F2	Inpatient Admin., Courtesy, Policy, & Other Disc. & Adj.	43,451,612	87,974,011	131,425,623
F3	Outpatient Hscrc Approved Discounts & Differentials	117,228,888	0	117,228,888
F4	Outpatient Denials	27,285,626	3,429,454	30,715,080
F5	Outpatient Admin.,Courtesy,Policy & Other Disc.& Adj.	11,574,670	309,098,596	320,673,266
F6	Total Disc.,Diffs, Denials & Adj. (F+F1+F2+F3+F4+F5)	581,037,014	401,968,393	983,005,407
G	Deductions From Revenue, (D+D1+E+E1+F6)	1,326,365,057	422,092,055	1,748,457,112
H	Net Patient Revenues, (C-G)	7,800,807,774	449,565,012	8,250,372,786
I	Other Operating Revenues	138,115,077	171,286,347	309,401,424
J	Net Operating Revenues, (H+I)	7,938,922,851	620,851,359	8,559,774,210
	OPERATING EXPENSES:			
K	Salaries & Wages	3,108,741,013	334,902,505	3,443,643,518
L	Employee Benefits	677,936,223	60,194,868	738,131,091
M	Other Operating Expenses	3,362,876,391	272,250,725	3,635,127,116
N	Oper Exp (Excluding Depr & Int), (K+L+M)	7,149,553,627	667,348,098	7,816,901,725
O	Interest	140,128,242	1,342,220	141,470,462
P	Depreciation & Amortization	404,888,860	12,578,006	417,466,866
Q	Total Operating Expense, (N+O+P)	7,694,570,729	681,268,324	8,375,839,053
R	Excess(Def) Opr Revenues Over Exp, (J - Q)	244,352,122	(60,416,965)	183,935,157
S	Nonoperating Revenues	0	51,510,063	51,510,063
T	Nonoperating Expenses	0	44,681,800	44,681,800
U	Excess (Deficit) Revenue Over Expenses (R+S-T)	244,352,122	(53,581,885)	190,770,237

Calculations:			
REGULATED		EIPA	802,153
Gross Patient Revenues	9,127,172,831		
Deductions	1,326,365,057		
Net Patient Revenue	7,800,807,774		
Other Operating Revenue	138,115,077		
Net Operating Revenue	7,938,922,851	Reg Net Operating Revenue P/EIPA	9,897.02
Total Operating Expense	7,694,570,729		
Net Regulated Operating Profits	244,352,122	Reg Net Op Profit/Reg Net Patient Revenue	3.13%
Unregulated			
Gross Patient Revenues	871,657,067		
Deductions	422,092,055		
Net Patient Revenue	449,565,012		
Other Operating Revenue	171,286,347		
Net Operating Revenue	620,851,359		
Total Operating Expenses	681,268,324		
Net Unregulated Operating Profits	(60,416,965)	Unreg Op Profit/Unreg Net Patient Revenue	-13.44%
Totals			
Non Operating Revenue	51,510,063		
Non Operating Expenses	44,681,800		
Total Non Operating Profit	6,828,263	Non Op Profit/Non Op Revenue	13.26%
Net Patient Revenue	8,250,372,786		
Total Net Operating Revenue	8,559,774,210	Total Net Op Rev/EIPA	10,671.00
Total Operating Profits	183,935,157	Total Operating Profit/Total Net Operating Rev	2.15%
Total Non Operating Profits	6,828,263		
Total Profits	190,763,420	Total Profits/(Net Op and Non Op Revenue)	2.22%

Consolidated by Hospital 07/2007 - 03/2008

Revised 5/14/2008

Appendix IV – Moody's Investor Services Discussion Document on the Impact of Swap Arrangements

Moody's
U.S. Public Finance

February 2009

Interest Rate Swaps Cause New Liquidity Stress for Some Healthcare, Higher Education and other Not-for-Profit Borrowers

Rating Implications Will Depend on Borrowers' Other Credit Attributes

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Summary Opinion

Mark-to-market liabilities for long-dated fixed payer interest rate swaps have grown considerably over the last few months and pose new credit risks for not-for-profit hospitals, higher education institutions, and other not-for-profit borrowers. Over the past decade, the fair value of most swap agreements fluctuated within a relatively narrow band and the majority of borrowers met collateral calls with little difficulty. However, over the last few months most borrowers have seen the fair value of their swap agreements decline significantly, in some cases resulting in large collateral posting requirements. Combined with poor investment returns over the past year and deteriorated operating results for some rated borrowers, many organizations find themselves ill prepared for the sudden drain on liquidity that swap liabilities can cause.

This special comment addresses the rating implications of large mark-to-market swap liabilities and swap collateral posting requirements and provides examples of rating actions taken over the last several months. This report will not address the impact of this risk on governmental, housing and public infrastructure issuers as collateral posting is either uncommon or structured with different terms than for not-for-profit hospitals, higher education institutions, and other not-for-profit borrowers.

Moody's Investors Service

Interest Rate Swaps Cause New Liquidity Stress for Some Healthcare, Higher Education and other Not-for-Profit Borrowers

Swap Risks Can Add to Liquidity Stress

The current low interest rate environment poses two primary risks to borrowers with floating-to-fixed interest rate swaps. The first risk is that collateral calls or termination payments could significantly reduce the borrower's liquidity, although we recognize that this posting may be temporary, depending on market conditions. The second is that material swap liabilities could, especially in combination with investment losses, lead a borrower to violate financial covenants, such as liquidity covenants, under the bond indenture or related documents like bank liquidity agreements. Violating financial covenants can lead to further balance sheet deterioration as the remedies under bank liquidity agreements may include acceleration of principal payments under a term loan, immediate repayment of principal, or collateral posting to the bank. For borrowers affected by both of these risks, rating downgrades are possible. In the absence of a forbearance agreement from the creditor bank, and depending on the borrower's other credit strengths, such as the ability to generate liquidity through sales of assets or higher cash flow, the rating transition could be swift and possibly result in a multi-notch rating downgrade.

Critical Factors Impacting Swap Liabilities

*LIBOR curve is flatter than at the outset of many swap agreements

*The use of long-dated swaps is more common

Some Swap Market Valuations Have Declined Substantially

Recent large declines in the market valuation of swap agreements have primarily related to LIBOR-based fixed payer swaps. In recent years, a common strategy among hospitals, universities and other not-for-profit borrowers has been to issue variable rate debt paired with a fixed payer interest rate swap with a similar maturity. While market participants often refer to the resulting net debt structure as "synthetic fixed rate" debt, Moody's has never viewed these obligations as akin to true fixed rate debt because there are significant risks associated with swaps that are variable and unpredictable. These typically include basis risk, collateral posting risk, termination risk and counterparty risk[1].

Under a fixed payer LIBOR swap, a hospital or university issues variable rate debt and then enters into an agreement with an unrelated third party, whereby the issuer pays a fixed rate to a counterparty and, in return, receives a variable rate payment from the counterparty that is tied to a percentage of LIBOR. The counterparty floating rate payment is intended to be approximately equal to the variable rate debt service the issuer pays on its variable

Figure 1

Dramatic Increase in Swap Liabilities for Fixed-Rate Payers

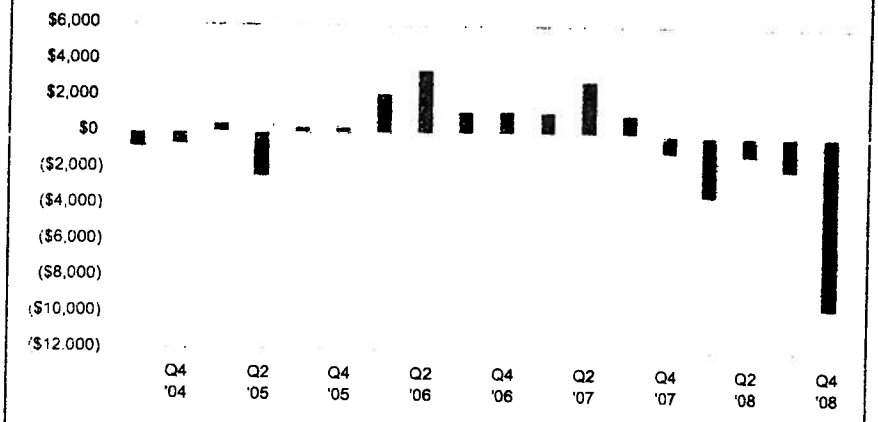


Chart depicting the historical mark-to-market value of a 20 year swap, expiring in 2023 with a notional amount of $110 million. Data provided by the hospital, which is the fixed-rate payer. Values are in $000's. Data are as of end of quarter.

[1] See the Rating Methodology: *Evaluating the Use of Interest Rate Swaps by U.S. Public Finance Issuers*, and the special comment: *Risks of Variable Rate Debt No Longer Hidden.*

rate debt[2]. Changes in the present value of the fixed and floating streams of payments will cause the market value of the swap itself to fluctuate.

A swap is valued based on the duration of the swap and the differences between the fixed rate and projections of the forward curve of the reference floating rate index. Increases in negative swap valuations have grown significantly over the past few months because long dated LIBOR rates have fallen (Figure 1). Although swap liabilities have eased from absolute lows in recent weeks, the valuations can change rapidly, and therefore collateral posting requirements could increase quickly.

Recent unprecedented developments in the debt capital markets have caused short term taxable rates and short term tax-exempt rates to trade at unusual levels. Specifically, the ratio of short term tax exempt to taxable rates (SIFMA vs. one-month LIBOR) has averaged 108% over the last four months (Figure 2), significantly higher than the 67% which is imbedded in many swap agreements (it is highly unusual for tax-exempt rates to be higher than taxable rates for significant periods of time).

Collateral Posting Absorbs Unrestricted Cash and Can Trip Bond Covenants

Posting collateral under swap agreements reduces financial flexibility for an unknown duration, and may require the borrower to issue more debt or liquidate long-term investments at unfavorable valuations to raise cash to meet collateral calls. As a result of its immediate impact on the balance sheet, collateral posting is of significant concern to all public finance borrowers, even if they are not subject to a strict liquidity covenant in related bond or bank documents. The duration and magnitude of collateral posting are key considerations in the rating impact of collateral calls.

Sample Collateral Posting Schedule For Swap With Liability of $12 million

Rating	*Threshold*	*Required Collateral Posting*
A2	Infinite	$0
A3	$10,000,000	$2,000,000
Baa1	$5,000,000	$7,000,000
Baa2 or Lower	$0	$12,000,000

Not-for-profit hospitals frequently covenant to maintain a minimum number of days cash on hand[3], as measured at specific points in time. This covenant often appears in bank liquidity agreements used to support variable rate demand bonds and sometimes in the master trust indenture. Collateral posting reduces the unrestricted cash available to meet a days cash on hand covenant and most not-for-profit hospitals, higher education institutions, and other not-for-profit institutions do not maintain sufficient lines of credit to cover collateral posting needs. Therefore, investments may need to be liquidated at distressed prices to raise cash for a collateral call. Although collateral posting will vary daily or weekly as the swaps are revalued, the duration of collateral posting is a key consideration because the days-cash and other covenants are frequently tested at the end of the fiscal year, or semi-annually (in some cases, the days cash covenant may be tested quarterly or more frequently).

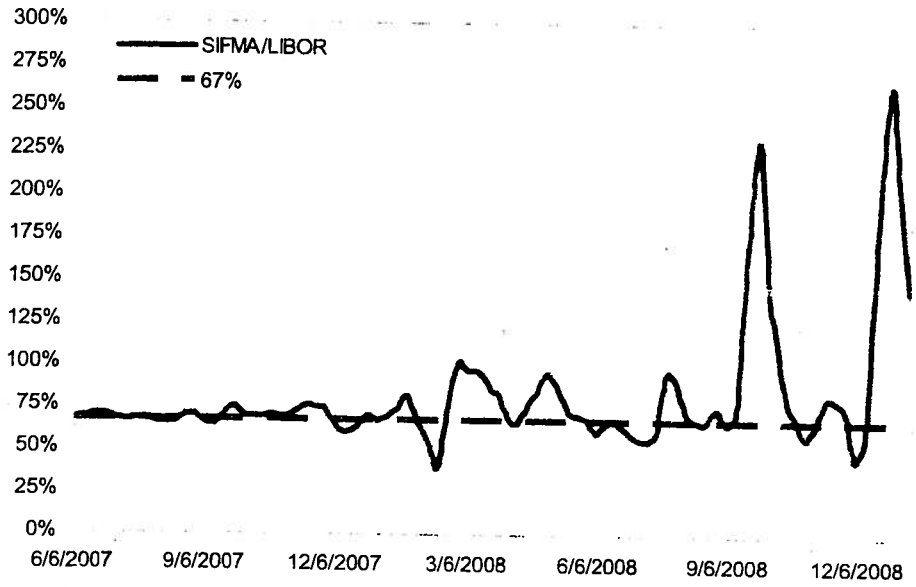
Some higher education and not-for-profit borrowers covenant to maintain a minimum net-assets to debt ratio[4] in indentures, bank or swap agreements. Swap liabilities directly reduce unrestricted net-assets and can cause borrowers to miss this covenant, even if the borrower is able to comfortably meet collateral calls (swap liabilities have no direct cash impact, unless they incorporate collateral posting or termination payments). Poor investment returns in 2008 and unusually large swap liabilities by historical standards have combined to reduce the unrestricted net assets of institutions with significant swap portfolios.

Cash or investments posted as collateral may still be recorded on the borrower's balance sheet, but will likely be presented on the face of the balance sheet as a separate line item and clearly identified as restricted. Ultimately, it is important to adhere to ratio definitions in the governing documents and verify exactly which entities are included in the obligated group when determining if a covenant violation has taken place.

[2] A risk of this strategy is basis risk—namely, that the variable rate the issuer receives is insufficient to cover the tax-exempt interest payments owed on the variable rate bonds.
[3] Unrestricted Cash and Investments x 365 divided by (Total Operating Expense – Depreciation Expense)
[4] Unrestricted Net Assets divided by Direct Debt

Figure 2

SIFMA-LIBOR Relationship More Volatile in 2008



Many swaps pay a floating rate of 67% of 1M LIBOR, which is close to the long-run SIFMA/LIBOR average of 71%. In the second half of 2008, this relationship broke down.

Source: Bloomberg, SIFMA website

Self-Liquidity Borrowers Face Special Liquidity Concerns

Collateral posting and swap termination payments may reduce a borrower's same day liquidity and could result in a downgrade of the short-term rating if the issuer has chosen to back its short-term debt obligations with its own liquidity. A key metric under the standard approach for rating self-liquidity programs is the ratio of same day liquidity to demand debt[5]. Issuers that manage self-liquidity programs need to demonstrate on an ongoing basis that they have enough same-day liquidity to meet the failed remarketing of variable rate demand bonds or the failed rollover of commercial paper, while still maintaining adequate liquidity to support the institution's ongoing operations. The need to post collateral to a swap counterparty can significantly reduce the levels of assets that were initially intended to be used for self-liquidity supported debt.

[5] For more information regarding the standard and modified approaches see the special comment: *Variable Rate Debt Instruments Supported by an Issuer's Own Liquidity*

Operational Burden of Collateral Posting

Many swaps require daily collateral posting, imposing an operational burden not planned for by most treasury operations. The treasury staff must be prepared to post collateral on short notice, and to monitor the mark-to-market valuation and request the return of collateral when the swap valuation moves in the borrower's favor.

Rating Considerations and Rating Transition Risk

The swap mark to market valuation represents the cost to the borrower to exit the swap. Some borrowers have signed agreements that do not require collateral posting unless their rating falls below Baa3. This is typical of most governmental borrowers outside the not-for-profit sectors. When collateral posting is required, it is typically only required for the portion of the swap liability that exceeds some threshold (as defined in the swap agreement). In some swap agreements, a downgrade of the borrower's rating may result in a lowering of the posting threshold, elimination of the threshold entirely, or termination of the swap.

Borrowers experiencing operating difficulties face significant risk that a downgrade by a rating agency could trigger additional collateral posting. Collateral posting that consumes a significant portion of a borrower's unrestricted liquidity, or which triggers accelerated repayment under reimbursement agreements, could result in rapid rating transitions. The impact on unrestricted liquidity is often more acute for hospitals than for higher education borrowers given hospital's more variable daily liquidity needs.

Although the rating level terms governing collateral posting in each swap are unique, many borrowers rated below Aa have relatively low thresholds and those in the Baa category may have thresholds of zero, requiring collateral posting equal to the fair-market liability of the swap. Most swaps allow the counterparty to terminate if the borrower's rating falls below investment grade. Therefore, the rating transition for lower rated borrowers could be faster and more severe than for higher rated borrowers.

The ultimate rating outcome for borrowers with large swap liabilities will depend on several factors including:

- Magnitude of the liability related to unrestricted liquidity
- Size and duration of collateral posting
- Sensitivity of swap portfolio valuation to interest rate changes
- Other demands on liquidity including self-liquidity, commitments under Letters of Credit (LOC), and ongoing capital projects
- Ability to increase cash flow through revenue increases or expense reductions
- Ability to liquidate other investments
- Likelihood of missing covenants and remedies available to creditor banks
- Diversification and ratings of swap counterparties

Conclusion

Borrowers experiencing operating difficulties, or with other significant demands on liquidity are most exposed to a rating downgrade driven, at least in part, by unfavorable swap valuations. Demands on liquidity are most pronounced for borrowers with self-liquidity, or those that are close to violating financial covenants, but can also impact borrowers with significant pending equity contributions on capital projects currently underway, or even near-term pension payments. Because most bank liquidity agreements for variable rate demand debt grant the bank broad rights to declare the principal immediately due and payable, the likelihood of missing these covenants is a key rating consideration.

Appendix V – Summary of Reports on Economic Activity 2009-2009

Inflation and changes in the GDP

16 March 2009

Inflation

The BLS reports that for the year ended January 2009 the increase in the CPI-U was 0% from the previous year.

The Producer Price Index for finished goods dropped by 1% from January 2008 to January 2009. For intermediate goods the drop was 0.7% and for crude goods the drop was 2.9%.

The price index for gross domestic purchases, which measures prices paid by U.S. residents, decreased 4.1 percent in the fourth quarter, 0.5 percentage point less of a decrease than in the advance estimate; this index increased 4.5 percent in the third quarter.

Economic Activity

The Bureau of Economic Analysis reports that GDP dropped 0.5% in the third quarter of 2008, and then 6.2% in the 4th quarter of 2008. Bloomberg predicts a drop of at least this magnitude for quarter 1 2009.

The decrease in real GDP in the fourth quarter primarily reflected negative contributions from exports, personal consumption expenditures, equipment and software, and residential fixed investment that were partly offset by a positive contribution from federal government spending.

Real personal consumption expenditures decreased 4.3 percent in the fourth quarter, compared with a decrease of 3.8 percent in the third.

Real nonresidential fixed investment decreased 21.1 percent, compared with a decrease of 1.7 percent. Nonresidential structures decreased 5.9 percent, in contrast to an increase of 9.7 percent. Equipment and software decreased 28.8 percent, compared with a decrease of 7.5 percent.

Real residential fixed investment decreased 22.2 percent, compared with a decrease of 16.0 percent.

Real exports of goods and services decreased 23.6 percent in the fourth quarter, in contrast to an increase of 3.0 percent in the third.

Real imports of goods and services decreased 16.0 percent, compared with a decrease of 3.5 percent.

Real federal government consumption expenditures and gross investment increased 6.7 percent in the fourth quarter, compared with an increase of 13.8 percent in the third. National defense increased

3.1 percent, compared with an increase of 18.0 percent. Nondefense increased 15.1 percent, compared with an increase of 5.1 percent.

Real state and local government consumption expenditures and gross investment decreased 1.4 percent, in contrast to an increase of 1.3 percent.

The real change in private inventories added 0.16 percentage point to the fourth-quarter change in real GDP, after adding 0.84 percentage point to the third-quarter change. Private businesses decreased inventories $19.9 billion in the fourth quarter, following a decrease of $29.6 billion in the third quarter and a decrease of $50.6 billion in the second.

February Report from the Federal Reserve Districts reflect a "severe contraction" in economic activity (February 2009)

Inflation

Prices and wages – Upward price pressures very limited during the reporting period, as a result of lower energy and commodity prices and weak demand for final goods. Lower input prices were passed on generally and contributed to downward pressures on final prices of various products.

Upward wage pressure eased in all Districts as a rising of hiring freezes and continued job cuts increased the degree of labor market slack. Contacts from various Districts pointed to a higher incidence of wage freezes resulting from the added slack, with a few noting outright wage reductions.

Economic Activity

Manufacturing sector seeing sharp declines in most sectors with very few bright spots

Real estate and construction – in the doldrums in most areas and housing price declines continue with no signs of deceleration

Banking and Finance – availability of credit remains tight causing large declines in this sector and across the economy

Agricultural and Natural Resources – conditions weakened in most districts as demand fell and growing conditions were mixed. Activity slowed significantly for producers of natural resource products.

FINAL RECOMMENDATION REGARDING MODIFYING THE QUALITY-BASED REIMBURSEMENT INITIATIVE AFTER STATE FY 2010

Health Services Cost Review Commission
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Baltimore, MD 21215
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May 7, 2009

This document is a final staff recommendation to the Commission at the May 13, 2009 public meeting.

Background

The Maryland Health Services Cost Review Commission at its June 4, 2008 meeting approved the staff recommendation titled, "Final Staff Recommendations regarding the HSCRC's Quality-Based Reimbursement (QBR) Project - based on Deliberations of the Initiation Work Group (IWG)." The QBR Initiative's development and implementation are based upon the deliberations and analysis performed by the HSCRC staff, the IWG, the Evaluation Work Group (EWG), and Commission consultants over the past several years. The IWG completed its work in June 2008 and the EWG was then established to: provide a system for developing new measures, retiring old measures, and recommending other adjustments to the data and scoring; ensure that the QBR Initiative was meeting its established goals; and to support and advance the rationale for linking hospital performance to payment.

For the first year of the QBR Initiative, the approved recommendations included using data for 19 process measures across four clinical topics including heart attack, heart failure, pneumonia and surgical care. For these measures, the additional approved recommendations included:

- incorporating new definitions for these core measures as they become available from CMS and the Joint Commission;
- weighting the scores for each process measure equally;
- establishing one index for the process measures for purposes of scoring, anticipating that reporting will be on performance for each clinical topic separately;
- utilizing an opportunity model for scoring purposes, whereby a hospital receives credit for each time the measure is performed, and the hospital's available points will be 10 times the number of applicable quality measures;
- utilizing calendar year 2007 as the base period and calendar year 2008 as the measurement period, establishing the scale for calibrating performance based on the prior year's experience so that thresholds and benchmarks are known in advance;
- counting (for purposes of scoring) the "higher of" either attainment or improvement points on each process measure for each hospital – on a 10 point scale for each measure;
- establishing the threshold for attainment at the 50th percentile benchmark at 95th percentile for the non-topped off measures, and for topped off measures, a score of 0.65 and 0.90 respectively;
- applying rewards and incentive payments maintaining revenue neutrality in FY 2010 as part of the FY 2010 update factor for individual hospitals;
- utilizing an exchange rate function (cubed-root functional form) for translating scoring into rewards/incentives without high or low restrictions on eligibility or rewards/incentives achieved;
- establishing a rule to adjust for "down and up" year to year performance on any individual process measure, establishing the base-line for improvement as that hospital's best previous score on that measure;

- establishing a mechanism where the Commission can obtain necessary data directly from hospitals through its own vendor arrangement based on work with the Maryland Health Care Commission (MHCC) through a contract with a data vendor to collect quality data for both MHCC's quality performance guide and the HSCRC QBR Initiative;
- moving over time toward use of complete data and away from sampling;
- assuring public accountability by providing accessibility to data with necessary restrictions on confidentiality;
- carefully planning and manage the public release of quality-related scoring information;
- determining the amount of funding "at-risk" based on further deliberations and recommendations of the HSCRC Payment Work Group comprising HSCRC staff and the hospital and payer industries, and approval of the Commission;
- scaling reward and incentive payments in the update factor for hospitals reporting on a minimum of 5 measures; and,
- investigating the feasibility in future years of incorporating additional funding ("new money") into the system if Maryland as a state can achieve certain benchmarks vs. the performance of hospitals nationally on the selected performance measures.

Status of QBR Initiative Implementation

Hospital rate adjustments will be made for FY 2010 within the parameters of the recommendations specified above. The amount of funding "at risk" for the first year must still be approved by the Commission, and data on the process measures for CY 2008 is in the process of being obtained by the Delmarva Foundation for analysis to calculate hospitals' improvement and attainment scores. The data vendor has been procured by MHCC, with patient-level data collection by the vendor on the process measures beginning with first quarter CY 2009. The EWG has met regularly to deliberate: measure additions, changes, and deletions; changes to the benchmark and threshold values for topped off measures; and the use of a blended appropriateness and opportunity model for the process measures in order to raise the bar of performance and better distinguish hospital performance in light of the increasing number of topped off measures. A call for comments was broadly disseminated and posted to the HSCRC website on the April 3, 2009 Draft Recommendation presented at the April 15, 2009 Commission meeting, with a comment submission due date of May 6, 2009; comments received did not necessitate substantive changes to the April 3, 2009 Draft Recommendations.

Recommendations to Complete Implementation of the QBR Initiative for the Initial Year

- The amount of funding "at risk" in the Rate Year 2010 will be determined in 2009 based on the recommendations of the HSCRC Payment Work Group and approval of

the Commission of the Final Recommendation of the HSCRC 2010 Hospital Payment Update.

- Consistent with the Joint Commission, CMS and MHCC initiatives, retire pneumonia 5b, Antibiotic within 4 hours, and replace it with pneumonia 5c, Antibiotic within 6 hours.

Recommendations for Changes to the QBR Initiative For Rate Years after FY 2010

- Consistent with the Joint Commission, Hospital Compare, and/or CMS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiatives' changes to the core measures, adopt the following modifications to the QBR measures:
  - PN 1- Oxygenation Assessment- retire this measure from use in the QBR beginning with January 1, 2009 discharges.
  - AMI 6- Beta Blocker at Arrival within 24 hours- retire this measure beginning with April 1, 2009 discharges.

- Expand current surgical care SCIP 1, 2, and 3 measures beyond hip, knee and colon surgery patients to include CABG, Other Cardiac, Hysterectomy, and Vascular Surgery with discharges beginning January 1, 2009; these measures include:
  - SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision
  - SCIP INF 2- Antibiotic selection
  - SCIP INF 3- Antibiotic discontinuance within appropriate time period postoperatively

- Add new process measures consistent with MHCC's timeframe for adding these measures to the Hospital Performance Evaluation Guide:
  - AMI 8- Percutaneous Coronary Intervention Timing for AMI patients– base CY 2008, measurement CY 2009, and rate year FY 2011
  - SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered - base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery–base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP CARD 2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period – base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP Inf – 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose - base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP Inf 6- Surgery Patients with Appropriate Hair Removal - base CY 2009, measurement CY 2010, and rate year FY 2012

- Children's Asthma Care Asthma Measures (CAC-1-3)- base CY 2010, measurement CY 2011, and rate year FY 2013; these measure include:
  - CAC 1- Systemic Relievers for Inpatient Asthma
  - CAC 2- Corticosteroids for Inpatient Asthma
  - CAC 3- Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver

- To mitigate the effects of topped off measures better distinguishing hospital performance, and to raise the performance bar, adopt a hybrid of the opportunity and appropriateness models where hospital scores are based 75% on opportunity and 25 % on appropriateness for base CY 2008, measurement CY 2009, and rate year FY 2011.

- Topped off Measures Definition – Based on analysis of the data already completed, change the definition of a topped off measure where the 75th percentile is within 2 standard errors of the 95th percentile, increased from the 90th percentile, for rate year adjustments beginning FY 2011.

- Patient Experience of Care – Based upon the results of analysis of patient experience of care measures data (HCAHPS) relative to other domains of quality measures, and upon proposed modeling of incorporating the patient experience domain in the QBR formula, allow the option of including this domain for future years.

Maryland
Hospital Association

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May 6, 2009

Robert Murray
Executive Director
Dianne Feeney
Associate Director, Quality Initiative
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Murray and Ms. Feeney:

I am writing to provide comments on the *Final Draft Recommendation Regarding Modifying the Quality-Based Reimbursement (QBR) Initiative After Rate Year State FY 2010.*

The Maryland Hospital Association (MHA) supports the developmental work of the Initiation Work Group and the subsequent efforts of the Evaluation Work Group to implement a system that links hospital performance to payment based on evidence-based research. We appreciate the broad-based and deliberative process the HSCRC has put in place to meet the established objectives of this important program.

The proposed changes in the April 24 Final Draft Recommendation continue to support and advance the QBR Initiative, and we believe the HSCRC should adopt them. We offer the following comments on specific aspects of the proposal:

- **Measures**: From the inception of this initiative, we have advocated that the HSCRC coordinate this program with the work of the Maryland Health Care Commission (MHCC) in identifying, vetting, and developing new measures for public reporting. Accordingly, we support changes to retire selected measures and add new ones consistent with the MHCC's time frame for doing so.

- **Scoring methodology**: It is important to evaluate the scoring approach and make necessary adjustments as the program evolves. We support a blending of the opportunity and appropriateness models, where scores are based 75 percent on opportunity and 25 percent on appropriateness.

- more -

- **Definitions**: For the first year of the QBR Initiative, the Centers for Medicare and Medicaid Services' definition of "topped off" measures was used. The proposed modification to the definition is more appropriate for the number of hospitals in Maryland.

- **Patient Experience of Care**: The draft recommendation includes an express provision to allow the option of incorporating patient experience of care measures, referred to as HCAHPS, in future years. This domain of measures obviously is not based on scientific evidence, and the consultants advising the Evaluation Work Group have indicated that current studies show only a weak correlation between HCAHPS measures and other quality measures. The HCAHPS survey tool is an excellent one for internal hospital use to foster improvement, but linking performance on these measures to payment requires much more thoughtful analysis and discussion. We look forward to working together with the HSCRC staff and others to further examine the appropriateness of using HCAHPS measures in the QBR Initiative at some point in the future. Presently, we recommend using measurable clinical quality indicators to achieve the goal of improving quality outcomes in Maryland hospitals.

MHA appreciates the opportunity to participate in the Evaluation Work Group process and to provide comments on the recommendations for changes to the QBR Initiative for rate years after 2010. If you have any questions or would like additional information, please do not hesitate to contact me.

Sincerely,

Beverly L. Miller
Senior Vice President, Professional Activities

Revised Draft Staff Recommendations Regarding HSCRC Payment Policy for Highly Preventable Hospital Acquired Conditions

Health Services Cost Review Commission
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May 8, 2009

This document represents a revised draft recommendation presented to the Commission on May 13, 2009. Comments on this recommendation should be sent to the attention of Robert Murray, Executive Director, HSCRC, by Wednesday, May 27th, 2009.

Background

In March the Commission approved a payment policy based on 11 Maryland Hospital Acquired Conditions (MHACs). The MHACs are a subset of the 64 potentially preventable complications (PPCs) developed by 3M. The 11 MHACs were chosen for several reasons:

- They are conceptually similar to the hospital acquired conditions (HACs) developed by CMS;

- They were judged the "most highly preventable" of the 3M PPCs, and therefore amenable to a straightforward payment adjustment.

In the course of the discussion of the MHAC policy recommendation, several concerns were raised about the MHAC approach. Primary among those concerns were the following:

- MHACs are case specific. Adjustments to allowable charges are calculated based on specific cases, leading to debate on whether the adjustment was correct in that specific case, and conversely, cases where an adjustment was clearly appropriate not occurring. In other words, disagreement over the likelihood of false positives and false negatives.

- MHACs are narrowly focused. The choice of only 11 MHACs effectively narrows the focus of the quality incentive that the Commission is trying to introduce. It should be noted that the MHACs are broader than the CMS HACs, but still narrower than is desirable.

As part of his motion at the March meeting approving the MHAC policy, Commissioner Wong directed staff to continue to look at the list of conditions that were candidates for MHACs and to consider deletions or expansions to the MHAC approach that would address some of the concerns that arose in the discussions. Additionally, Commissioner Sexton strongly encouraged staff to look at alternative, more balanced and more macro method of incentives to help the industry focus on sustained quality improvement.

Additional Analysis

Staff, in cooperation with 3M, has in turn developed an alternative approach. The revised approach improves on MHACs in two ways. First, it moves from the case specific mechanism of MHACs to a broader, rate-based approach. Second, it expands the number of conditions included for consideration when assessing hospitals. The revised approach leverages one of the key features of the MHAC payment adjustment: the regression determined adjustment to outlier payments. The new approach, however, applies that analysis more comprehensively.

Regression Results

3M has estimated a dollar impact for each of the 64 PPCs using a regression analysis. Essentially, the regression estimates the amount of additional charges that result from each

PPC. In the current MHAC policy these regression results are used to adjust payments where there are outlier charges or the APR-DRG assignment changes. In the revised approach these estimates of additional charges are used to create an index of either additional, or averted, resource use based on a hospital's rate of potentially preventable complications.

The regression analysis looked at patients' admission DRG and compared that with the additional charges associated with each of the 64 PPCs. Not all PPCs lead to statistically significant additional charges. For eleven (11) PPCs the T value in the regression was less than 1.96 indicating that the difference between the mean of the average charge with and without the particular PPC was not statistically significant. Specifically, PPCs 26, 30, 43, 46, 55, 57, 58, 59, 60, 61, 62 do not have statistically significant charge estimates. Appendix A contains the estimation calculation for the regression analysis.

Using the Regression Results to Create a Hospital Index

Using the results of the regression 3M has calculated the FY08 impact on each hospital for which we have acceptable coding of present on admission (POA)- 43 out of 47 hospitals. This was done by comparing the hospital's actual PPC incidence with the expected statewide incidence. The expected value of PPCs is the number of PPCs a hospital, given its mix of patients as defined by APR DRG category and severity of illness level, would have experienced had its rate of PPCs been identical to that experienced by a reference or normative set of hospitals. This is discussed more completely in the Technical Note in Appendix B.

For each hospital 3M calculated the statewide average for each PPC, compared to the hospital's rate. Where:

PPC = Each of the 64 PPC
A = the hospital' actual rate of the PPC
E= the hospital's expected rate of the PPC
RA = the regression determined statewide adjustment for the PPC
SF = the hospital's standardization factor

IMPACT=PPC (A-E)*RA= Difference for expected resource use for the PPC.
SF*IMPACT = Adjusted Difference for expected resource use for the PPC.

The sum of each individual PPC difference from resource use for the hospital yields an overall impact for the hospital. Since the charge values in the regression file used standardized charges, the additional per case charge value for each PPC represents a statewide estimated and should be converted back to a hospital specific value by the ratio of the hospital CPC divided by the statewide average CPC. The results for each hospital and each PPC are presented in Appendix C, Table 3.

In estimating these results we have made a zero adjustment for the 11 PPCs where the T test was not significant. In addition, we drop PPC 63, for the same reasons that were identified in the development of the MHAC policy. So, our analysis is based on 52 PPCs.

This analysis yields an estimate of excess, or avoided, resource use for each hospital based on their PPC performance. Staff considered two approaches to normalizing these dollar estimates to the size of the hospital. The first was to rank hospitals on the basis of their percentage of total inpatient charges, and the second was based on the percentage of total charges that are at risk of incurring a PPC that is not globally excluded. Appendix D, Table 4 presents each hospital in terms of its performance on this index using both normalizing approaches. Hospitals with higher number rankings are the poor performers in that these hospitals have a high rate of adjustment relative to total inpatient charges. The scaling approach has little effect on the rankings of the hospitals.

The statewide average value for each of the PPCs was calculated by APR-DRG and by severity of illness (SOI) categories 1 through 4. Due to the volume of the data, this information is accessible upon request.

Some observations:

- The results, especially for poor performers, are generally consistent with findings from the process measures the Commission has developed.

- The results seem to indicate some positive and negative hospital enterprise system effects, as illustrated by Tables 2 and 3 (in the attached Appendix B and C) which display hospital-specific results.

- There do not appear to be reporting issues. Staff was concerned that hospitals that tended over-code diagnoses as present on admission would look better than other hospitals. This is because if a diagnosis was present on admission it, by definition, cannot be a preventable complication for that admission. Staff looked at the POA coding feedback reports and found no discernible relationship between high rates of POA reporting and improved performance on the PPC scale. Going forward, our auditing strategy will need to be adjusted to assure integrity of POA coding.

Transparency, Reporting and Vetting the Revised Approach

Over the last several weeks, HSCRC staff has convened the MHAC Work Group as well as a technical subgroup to vet and further refine the revised methodology. Hospital industry representatives were generally supportive of the revised methodology and uniformly indicated it was an improvement over the previously approved MHAC methodology. This technical group emphasized the importance of transparency in the methodology and hospital-specific results so as to provide the clearest incentives for hospitals. A technical subgroup is scheduled to meet on May 13th, 2009 to determine the layout and content of hospital specific MHAC/PPC reports. To this meeting we have invited representatives from the various hospital peer groups, including small hospitals, as well as MHA, 3M, St. Paul Computer Center, and consultants to the industry to ensure that data reports are developed as efficiently as possible and are as useful as possible. Hospital case mix, finance, and quality staff have also been notified of a statewide technical meeting that HSCRC is convening on May 19, 2009 to review methodology and the calculations so hospitals are able to replicate their own MHAC/PPC rates. HSCRC will

continue to work with the industry and other stakeholders to identify and resolve technical issues as they come up during the implementation of the revised approach.

Benefits of the Revised MHAC Approach

The benefits of using the revised MHAC approach are summarized below:

- The revised approach moves away from a case by case approach where providers feel specifically targeted to one that considers aggregate rates of PPCs, in keeping with the fundamental rate setting system.

- The original focus on a case-specific payment decrement methodology inevitably lead to a focus on the need for the use of complication categories that were 100% preventable (as validated by rigorous scientific research). Conversely, use of a rate-based system that calculates actual versus expected values of PPCs that is risk adjusted based on the APR-DRG methodology and SOI patient mix of the hospital removes the clinical concern of level of preventability, and the use of the statewide average as the expected benchmark is one that is/should be reasonably achievable.

- The revised approach removes or greatly diminishes the concern that legal action may be taken against a specific provider on a specific case.

- The revised approach shifts from a punitive model that removes revenue from the system to one that rewards good performers and penalizes bad performers in a revenue neutral manner.

- The proposed broader list of PPCs allows for hospitals to spread their risk more broadly; however, the amount of revenue "at risk" is a separate discussion and is not related to the methodology per se.

- Compared with an alternative approach using the admission DRG for payment purposes, embedding higher payments at the APR DRG charge per case level, the revised approach incents complete coding by the hospitals, and clearly shows evidence of quality improvement for each of the individual PPCs and in the aggregate as the rates improve.

- Related to the clear evidence of quality improvement, the revised approach demonstrates to CMS and the public at large that there is a focus on decreasing hospital acquired conditions in Maryland that has greater potential for positive impact.

Summary of Draft Recommendations

This alternative approach to the initial MHAC recommendations addresses the most significant concerns raised during the discussion of MHACs. Staff makes the following draft recommendations:

- Adopt an initial broad based set of statistically significant (currently defined as 52) MHAC/PPCs to avoid focusing attention on a specific subset of procedures, hospitals, or providers.

- Implement a rate-based, rather than case specific, approach where hospitals are compared based on their performance relative to the statewide average for each selected PPC, eliminating the discussions and concern of the relative preventability of a specific case.

- Implement scaling of hospital payment adjustments so that a hospital's performance on the PPC methodology, either positive or negative, is reflected in its update factor (the magnitude of fund scaled and the precise methodology should be established in the .

- Rank hospitals based on the amount of hospital charges that are at risk of incurring a PPC that is not globally excluded, when normalizing the performance results of hospitals (Table 4 in Appendix D shows the PPC rankings based on the amount of quantified additional or averted resource use as a percentage of "at-risk" revenue and also as a percentage of total hospital revenue).

- Implement this revised approach (initially using the 52 selected PPCs) with discharges beginning FY 2010 (July 1, 2009), and use FY 2009 MHAC/PPC performance data to establish the normative statewide average performance statistics by APR-DRG and by SOI.

- Similar to the QBR initiative, implement a revenue neutral approach, determining the amount of revenue at risk (the dollar amount scaled) in the context of anticipated future rate updates and other considerations.

- Consistent with the process for the APR-DRGs, provide a mechanism on an ongoing basis to receive input and feedback from the industry and other stakeholders to refine and improve the MHAC/PPC codes and logic.

- Make a tracking tool reasonably accessible to hospitals so that they may track their performance throughout the measurement year.

Next Steps

If the Commission believes this general approach is superior to the previously approved MHAC methodology, staff will move deliberately to address the reporting issues noted earlier in this document. At the technical meeting with hospital representatives on May 5th, staff also identified a several issues that will need to be resolved prior to a finalization of the payment/scaling methodology associated with this revised MHAC design.

Appendix A:

Technical Note on Estimating the Marginal Additional Charge of PPCs in Maryland

Objective: Estimate the marginal hospital charge increase when a patient develops a PPC during a hospital stay (i.e., acquired post admission) in Maryland.

Data Source: Maryland inpatient acute care all payer statewide hospital data from July 2007 through June 2008 containing 765,519 discharges were used as the basis for the estimates. In Maryland hospitals are required to specify whether each reported diagnosis was present at admission (POA). Since the requirement to report the POA status of each diagnosis is a new requirement, hospitals with poor quality of the reporting of the POA status were excluded from the analysis. Discharges that died or were transferred to another acute care facility were excluded. Further, discharges with charge values below $200 or above $2,000,000 were excluded. Individual case level charges were standardized based the ratio of the statewide average hospital CPC $9,959.11 to the hospital average CPC (CMI of 1.0). The resultant analysis file contained 659,816 discharges.

Method: Since the marginal charge impact of a PPC, will vary depending on a patient's reason for admission and severity of illness at the time of admission, it was necessary to adjust for these factors in order to determine the marginal charges of a PPC. 3M All Patient Refined Diagnosis Related Groups (APR-DRGs) classify discharges to one of 314 reasons for admission and one of four severity of illness levels (1,256 unique patient categories). Each discharge in the analysis database was assigned to an APR DRG v26.1. Since patients who develop a post admission complication often develop multiple associated complications, it was necessary to adjust for the presence of multiple complications in order to determine the marginal charge of an individual PPC. 3M Potentially Preventable Complications (PPCs) v26 identify 64 different types of post admission complications analyzing 1,450 ICD-9-CM diagnosis codes and a select set of procedure codes. All PPCs present on each discharge (potentially preventable or not) were identified and used in the regression analysis.

A simple linear regression was specified of the form:

$$\text{Charge}_i = \alpha + \beta_j \text{PPC}_{j,i} + \gamma_k \text{APR-DRG}_{k,i} + \varepsilon_i$$

Where:

Charge_i is the total charge standardized for discharge i

$\text{APR DRG}_{k,i}$ is a binary variable (0,1) indicating which of the 1,256 APR DRGs was assigned to the i^{th} discharge

$\text{PPC}_{j,i}$ is a binary variable (0,1) indicating which of the j PPCs were present for the i^{th} discharge

α is a constant value applied to each discharge in the model. α is the average baseline charge for a reference APR DRG.

γ_k is the coefficient associated with APR-DRG k and measures the marginal additional charge above α that is due to the patient's reason for admission and severity of illness level at the time of admission.

β_j is the coefficient associated with PPC j and measures the marginal additional charge above α that is due to the presence of PPC j

ε_i is the residual error of the model for discharge i

The coefficient β_j for each PPC is a measure of the marginal additional charges due to the occurrence of the PPC taking into account the patient's reason for admission, severity of illness and the presence of any other post admission complications (PPCs).

The initial Maryland data set contained 659,816 discharges. 38,211 discharges were assigned to one or more PPCs. Cases in low volume APR-DRGs were omitted from the regression. Further, cases in APR-DRG cells that had significance (t) values below 95% were also omitted from the regression since their coefficients are indicative of too wide a dispersion of values. No effort was made to identify and exclude outlier cases.

Results: A regression model was calculated. For each of the PPC categories, coefficients (additional per case charges) and t-values are shown in table 1 below.

The results of the regression are used for computing the dollar impact for each of the 64 PPCs. The dollar impact is used to create an index of either additional, or averted, resource use based on a hospital's rate of a PPC summed across all PPCs. Eleven (11) PPCs with less predictive t-values (under 1.96) were excluded from the quality based payment adjustment PPC policy. Since the charge values in the regression file used standardized charges, the additional per case charge value for each PPC needs to be converted back to a hospital specific value by the ratio of the hospital CPC divided by the statewide average CPC of $9,959.11.

Table 1. PPC Charge Regression

PPC #	PPC Description	Additional Charge Amont	T-Stat	Cases	Notes
			T Value<1.96		
1	Stroke & Intracranial Hemorrhage	$13,066	38.603236	828	
2	Extreme CNS Complications	$12,051	30.374969	644	
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	$5,721	40.425129	5257	
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	$20,064	60.367208	898	
5	Pneumonia & Other Lung Infections	$13,561	93.165292	4850	
6	Aspiration Pneumonia	$10,500	43.489609	1667	
7	Pulmonary Embolism	$10,735	26.962321	601	
8	Other Pulmonary Complications	$7,791	53.427777	4764	
9	Shock	$11,109	42.074928	1512	
10	Congestive Heart Failure	$3,895	19.431952	2386	
11	Acute Myocardial Infarction	$5,643	20.335337	1232	
12	Cardiac Arrythmias & Conduction Disturbances	$2,418	6.8716698	1017	
13	Other Cardiac Complications	$3,197	7.6846559	537	
14	Ventricular Fibrillation/Cardiac Arrest	$15,459	41.038245	680	
15	Peripheral Vascular Complications Except Venous Thrombosis	$12,992	24.113279	325	
16	Venous Thrombosis	$10,758	44.449833	1670	
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	$11,231	34.432863	882	
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	$14,354	23.898709	258	
19	Major Liver Complications	$10,045	19.089809	341	
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	$8,672	19.123975	459	
21	Clostridium Difficile Colitis	$16,495	61.368894	1323	
22	Urinary Tract Infection	$6,462	55.126985	7186	
23	GU Complications Except UTI	$4,692	11.488989	559	
24	Renal Failure without Dialysis	$7,920	64.262455	6516	
25	Renal Failure with Dialysis	$41,186	58.790771	191	
26	Diabetic Ketoacidosis & Coma	$1,445	1.2998569	75	
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	$4,256	14.864072	1151	
28	In-Hospital Trauma and Fractures	$4,816	8.8928586	321	
29	Poisonings Except from Anesthesia	$1,415	2.5293641	297	
30	Poisonings due to Anesthesia	-$214	-0.044442	4	
31	Decubitus Ulcer	$18,231	60.306088	1054	
32	Transfusion Incompatibility Reaction	$48,575	13.275425	7	
33	Cellulitis	$2,864	11.067491	1502	
34	Moderate Infectious	$12,922	46.015837	1224	
35	Septicemia & Severe Infections	$14,088	82.951889	3957	
36	Acute Mental Health Changes	$3,631	13.302443	1252	
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	$15,778	55.698834	1313	
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	$30,875	24.884632	61	
39	Reopening Surgical Site	$13,777	14.66669	106	
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Pr	$6,536	39.763252	3575	
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	$11,158	17.164797	222	
42	Accidental Puncture/Laceration During Invasive Procedure	$3,836	16.569302	1858	
43	Accidental Cut or Hemorrhage During Other Medical Care	$722	0.7864481	114	
44	Other Surgical Complication - Mod	$12,509	28.382066	483	
45	Post-procedure Foreign Bodies	$5,203	2.6470991	26	
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	$6,574	0.9290811	2	
47	Encephalopathy	$10,182	38.081795	1343	
48	Other Complications of Medical Care	$10,588	41.930328	1479	
49	Iatrogenic Pneumothrax	$7,283	22.107326	900	
50	Mechanical Complication of Device, Implant & Graft	$14,138	35.609177	593	
51	Gastrointestinal Ostomy Complications	$20,608	40.248239	358	
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	$8,776	31.270093	1214	
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusion	$15,073	42.530628	770	
54	Infections due to Central Venous Catheters	$22,295	40.356236	312	
55	Obstetrical Hemorrhage without Transfusion	$159	0.9533953	3556	
56	Obstetrical Hemorrhage wtih Transfusion	$2,137	4.2845441	385	
57	Obstetric Lacerations & Other Trauma Without Instrumentation	$273	1.0950693	1532	
58	Obstetric Lacerations & Other Trauma With Instrumentation	$646	1.6310622	597	
59	Medical & Anesthesia Obstetric Complications	$487	1.2749917	654	
60	Major Puerperal Infection and Other Major Obstetric Complications	$94	0.164819	289	
61	Other Complications of Obstetrical Surgical & Perineal Wounds	$69	0.1035152	209	
62	Delivery with Placental Complications	$525	0.8839125	265	
63	Post-Operative Respiratory Failure with Tracheostomy	$115,361	91.791189	60	Removed from List
64	Other In-Hospital Adverse Events	$2,147	6.0351379	739	

Appendix B

Technical Note on Calculating Expected Values

The expected value of PPCs is the number of PPCs a hospital, given its mix of patients as defined by APR DRG category and severity of illness level, would have experienced had its rate of PPCs been identical to that experienced by a reference or normative set of hospitals.

The technique by which the expected value or expected number of PPCs is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a PPC, a condition called being "at risk" for a PPC. All discharges will either have no PPCs or will have one and possibly more PPCs. For this exercise, therefore, each discharge either has a PPC or does not have a PPC. The PPC rate is the proportion or percent of admissions which have at least one PPC.

The rates of PPCs in the normative database are calculated for each APR DRG category and its severity of illness levels by dividing the observed number of PPCs by the total number of admissions. The PPC norm for a single APR DRG severity of illness level is calculated as follows:

Let:

N = norm
P = Number of discharges with one or more PPCs
D = Number of discharges that can potentially have a PPC
i = An APR DRG category and a single severity of illness level

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

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

Once a set of norms has been calculated, they can be applied to each hospital. For this example, the computation is for an individual APR DRG category and its severity of illness levels. This computation could be expanded to include multiple APR DRG categories or any other subset of data, by simply expanding the summations.

Consider the following example for an individual APR DRG category.

Table 2: Expected Value Computation Example

1 Severity of illness Level	2 Discharges at risk for PPCs	3 Discharges with PPCs	4 PPCs per discharge	5 Normative PPCs per discharge	6 Expected # of PPCs
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	500	45	.09		56.5

For the APR DRG category, the number of discharges with PPCs is 45, which is the sum of discharges with PPCs (column 3). The overall rate of PPCs per discharge, 0.09, is calculated by dividing the total number of discharges with PPCs (sum of column 3) by the total number of discharges at risk for PPCs (sum of column 2), i.e., 0.09 = 44/500. From the normative population, the proportion of discharges with PPCs for each severity of illness level for that APR DRG category is displayed in column 5. The expected number of PPCs for each severity of illness level shown in column 6 is calculated by multiplying the number of discharges at risk for PPCs (column 2) by the normative PPCs per discharge rate (column 5) The total number of PPCs expected for this APR DRG category is the expected number of PPCs for the severity of illness levels.

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

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

Appendix C
Table 3: Detailed Provider Rates by PPC

Provider	Row	Hospital	Number of PPC Globally Excluded Cases	Charges for Globally Excluded Cases	% of At Risk Revenue	At Risk Inpatient Revenue	% of Total Inpatient Charges	Total Inpatient Charges	Minimum Number of Actual and Expected PPCs	0	PPC Regression Results
									Total Impact Using Statewide Avg Expected Times CPC Adjusted PPC Charge	Standardize Factor	Total Impact Using Statewide Avg Expected Times PPC Charge
210001	A	Washington County	3,673	$30,520,568	1.63%	$127,841,557	1.31%	$158,362,125	$2,081,389	0.85954	$2,421,516
	B										
210002	A	University Hospital	8,945	$332,159,388	2.19%	$530,562,602	1.35%	$862,721,990	$11,615,023	1.47602	$7,869,150
	B										
210003	A	Prince Georges	3,494	$41,032,419	7.37%	$126,865,954	5.57%	$167,898,373	$9,348,013	1.06131	$8,807,995
	B										
210004	A	Holy Cross	10,041	$53,950,798	0.53%	$233,562,653	0.43%	$287,513,451	$1,233,967	0.94786	$1,301,845
	B										
210005	A	Frederick	3,776	$26,629,419	-1.06%	$136,060,092	-0.89%	$162,689,511	-$1,447,123	0.87035	-$1,662,691
	B										
210006	A	Harford	486	$6,108,981	2.14%	$50,104,863	1.91%	$56,213,844	$1,071,434	0.89115	$1,202,305
	B										
210007	A	St. Joseph	3,979	$36,450,914	-1.28%	$241,905,297	-1.11%	$278,356,211	-$3,095,796	0.89080	-$3,476,079
	B										
210008	A	Mercy	4,024	$35,437,563	-2.96%	$157,835,394	-2.42%	$193,272,957	-$4,671,759	1.03732	-$4,503,682
	B										
210009	A	Hopkins Hospital	8,375	$227,496,706	0.45%	$666,182,598	0.33%	$893,679,304	$2,978,814	1.33763	$2,226,934
	B										
210010	A	Dorchester	331	$4,478,354	1.25%	$22,521,118	1.04%	$26,999,472	$280,402	0.85199	$329,114
	B										
210011	A	St. Agnes	3,041	$39,848,680	1.22%	$189,348,020	1.01%	$229,196,700	$2,310,837	1.01010	$2,287,731
	B										
210012	A	Sinai	5,310	$72,944,204	0.75%	$320,920,932	0.61%	$393,865,136	$2,408,304	1.06298	$2,265,615
	B										
210013	A	Bon Secours	736	$12,899,380	-2.11%	$56,162,746	-1.71%	$69,062,126	-$1,183,770	0.98856	-$1,197,469
	B										
210015	A	Franklin Square	4,796	$50,222,965	-2.20%	$235,088,284	-1.81%	$285,311,249	-$5,160,847	1.02572	-$5,031,438
	B										
210017	A	Garrett	459	$2,314,401	-2.42%	$16,265,235	-2.12%	$18,579,636	-$393,549	0.90732	-$433,749
	B										
210019	A	Pennisula Regional	4,204	$43,060,520	-0.97%	$214,005,509	-0.81%	$257,066,029	-$2,075,459	0.89224	-$2,326,122
	B										
210023	A	Anne Arundel	7,168	$37,317,415	-0.90%	$198,394,266	-0.75%	$235,711,681	-$1,778,855	0.87573	-$2,031,282
	B										
210024	A	Union Memorial	1,796	$39,626,042	-1.32%	$272,139,235	-1.15%	$311,765,277	-$3,589,778	1.07038	-$3,353,741
	B										
210025	A	Cumberland	1,501	$8,539,979	1.93%	$59,467,450	1.69%	$68,007,429	$1,149,316	0.92489	$1,242,652
	B										
210027	A	Sacred Heart	1,000	$13,004,206	-3.22%	$67,581,048	-2.70%	$80,585,254	-$2,176,914	0.84701	-$2,570,116
	B										
210028	A	St. Mary's	1,722	$7,769,238	-3.14%	$60,163,481	-2.78%	$67,932,719	-$1,888,875	0.90539	-$2,086,256
	B										
210029	A	Hopkins Bayview	3,993	$59,663,081	-0.64%	$220,735,037	-0.50%	$280,398,118	-$1,415,071	1.09757	-$1,289,277
	B										
210030	A	Chester River	544	$4,055,433	2.80%	$28,119,631	2.45%	$32,175,064	$786,683	1.03699	$758,621
	B										
210032	A	Union of Cecil 0907	1,316	$8,208,025	-0.73%	$54,686,369	-0.64%	$62,894,394	-$400,056	0.83156	-$481,091
	B										
210033	A	Carroll	2,269	$17,656,845	-3.24%	$122,265,308	-2.83%	$139,922,153	-$3,964,280	0.91807	-$4,318,059
	B										
210034	A	Harbor	2,780	$25,060,100	-1.97%	$122,060,440	-1.63%	$147,120,540	-$2,399,766	1.04318	-$2,300,433
	B										
210035	A	Civista 0807	1,401	$11,440,406	3.47%	$55,425,877	2.88%	$66,866,283	$1,925,627	0.97300	$1,979,061
	B										
210037	A	Easton	2,181	$14,868,868	-0.78%	$72,236,008	-0.65%	$87,104,876	-$563,551	0.90030	-$625,959
	B										
210038	A	Maryland General	2,889	$32,208,003	-2.17%	$107,777,422	-1.67%	$139,985,425	-$2,340,468	1.11653	-$2,096,198
	B										
210039	A	Calvert	1,445	$6,389,321	0.25%	$53,826,325	0.22%	$60,215,646	$134,954	0.89325	$151,082
	B										
210040	A	Northwest	1,077	$15,873,572	-1.35%	$104,376,194	-1.17%	$120,249,766	-$1,409,177	0.94175	-$1,496,338
	B										
210043	A	Baltimore Washington	1,792	$27,170,865	-0.23%	$157,965,637	-0.19%	$185,136,502	-$357,681	0.90340	-$395,927
	B										
210044	A	GBMC	6,214	$33,867,735	-0.60%	$171,125,088	-0.50%	$204,992,823	-$1,034,290	0.85840	-$1,204,905
	B										
210045	A	McCready	63	$547,793	-5.71%	$4,866,205	-5.13%	$5,412,998	-$277,593	0.95796	-$289,775
	B										
210048	A	Howard	4,057	$23,141,293	2.66%	$114,847,481	2.22%	$137,988,774	$3,059,376	0.90384	$3,384,864
	B										
210049	A	Upper Chesapeake	2,678	$17,354,305	0.70%	$113,678,423	0.61%	$131,032,728	$796,819	0.89743	$887,890
	B										
210051	A	Doctors	1,243	$20,229,484	8.66%	$87,673,611	7.03%	$107,903,095	$7,588,304	0.89643	$8,465,026
	B										
210054	A	Southern Maryland	3,049	$23,471,919	-1.91%	$133,986,519	-1.62%	$157,458,438	-$2,555,245	0.94245	-$2,711,280
	B										
210055	A	Laurel	1,135	$8,312,074	7.45%	$55,081,915	6.47%	$63,393,989	$4,102,475	0.97472	$4,208,875
	B										
210056	A	Good Samaritan	1,634	$28,730,954	-2.63%	$172,516,189	-2.26%	$201,247,143	-$4,542,206	0.96527	-$4,705,633
	B										
210058	A	Kernan	364	$7,672,415	1.23%	$39,119,430	1.03%	$46,791,845	$481,377	0.96901	$496,772
	B										
210061	A	Atlantic General	363	$4,748,671	1.07%	$32,476,185	0.93%	$37,224,856	$347,880	0.92164	$377,457
	B										
210904	A	Hopkins Oncology	3,712	$135,922,007	-0.54%	$20,147,932	-0.07%	$156,069,939	-$108,834	1.43800	-$75,684
	B										
		Total		$1,648,405,309		$6,027,970,561		$7,676,375,870	$4,870,049		$1,322

Case Differencial: The number of cases above or below the expected number of ca Level (ex - APR-DRG X, Severity Level 1)

Resource Use/Savings: The case difference times the regression results for each

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 1			PPC 2			PPC 3		
			$13,066			$12,051			$5,721		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	13,700	24	18.5	12,518	3	7.1	12,813	105	75.4
	B			5.48	$71,601		-4.13	-$49,769		29.63	$169,520
210002	A	University Hospital	22,559	61	48.6	21,413	23	16.6	22,186	254	311.4
	B			12.40	$162,017		6.40	$77,124		-57.42	-$328,512
210003	A	Prince Georges	11,528	8	10.0	10,795	12	3.6	11,030	37	47.6
	B			-1.99	-$26,001		8.38	$100,984		-10.62	-$60,759
210004	A	Holy Cross	22,799	13	20.4	20,673	5	7.6	21,346	80	83.0
	B			-7.39	-$96,557		-2.60	-$31,332		-3.03	-$17,335
210005	A	Frederick	15,249	23	18.3	13,861	6	7.2	14,439	98	84.1
	B			4.68	$61,148		-1.19	-$14,340		11.87	$67,911
210006	A	Harford	6,716	15	5.8	6,120	6	2.1	6,320	24	24.7
	B			9.22	$120,468		3.93	$47,359		-0.68	-$3,890
210007	A	St. Joseph	20,640	34	39.6	19,512	11	13.1	20,002	378	311.8
	B			-5.56	-$72,646		-2.08	-$25,065		66.16	$378,516
210008	A	Mercy	15,223	10	15.1	14,755	3	6.8	14,910	28	77.7
	B			-5.05	-$65,983		-3.75	-$45,190		-49.71	-$284,402
210009	A	Hopkins Hospital	27,910	77	75.7	25,675	37	24.0	27,076	516	393.8
	B			1.28	$16,724		12.96	$156,176		122.21	$699,190
210010	A	Dorchester	3,134	0	3.0	2,928	2	1.3	3,037	6	16.0
	B			-2.95	-$38,544		0.72	$8,676		-9.97	-$57,041
210011	A	St. Agnes	16,218	25	21.1	15,080	9	8.1	15,641	65	98.9
	B			3.94	$51,480		0.90	$10,846		-33.94	-$194,178
210012	A	Sinai	20,535	47	37.8	18,694	12	12.5	19,826	162	207.4
	B			9.20	$120,206		-0.51	-$6,146		-45.39	-$259,686
210013	A	Bon Secours	5,751	1	8.0	5,190	4	3.1	5,225	21	28.7
	B			-6.97	-$91,069		0.91	$10,966		-7.69	-$43,996
210015	A	Franklin Square	23,262	19	29.5	21,407	3	10.8	22,072	135	126.4
	B			-10.48	-$136,931		-7.81	-$94,115		8.63	$49,374
210017	A	Garrett	2,351	1	2.3	2,157	0	0.7	2,116	11	9.4
	B			-1.31	-$17,116		-0.71	-$8,556		1.58	$9,040
210019	A	Peninsula Regional	17,555	35	37.7	15,883	14	13.1	16,502	449	227.6
	B			-2.69	-$35,147		0.89	$10,725		221.43	$1,266,849
210023	A	Anne Arundel	19,825	19	24.3	18,209	8	9.0	18,738	138	101.8
	B			-5.27	-$68,857		-1.00	-$12,051		36.19	$207,051
210024	A	Union Memorial	18,254	31	42.9	17,507	13	13.8	17,824	116	353.5
	B			-11.89	-$155,354		-0.78	-$9,399		-237.49	-$1,358,732
210025	A	Cumberland	6,526	14	6.5	5,939	5	1.8	6,224	28	23.7
	B			7.47	$97,602		3.19	$38,441		4.26	$24,372
210027	A	Sacred Heart	8,117	14	13.0	7,261	4	3.8	7,075	31	88.2
	B			0.96	$12,543		0.25	$3,013		-57.18	-$327,139
210028	A	St. Mary's	8,508	5	6.4	8,029	1	2.4	8,311	6	31.7
	B			-1.37	-$17,900		-1.35	-$16,268		-25.71	-$147,092
210029	A	Hopkins Bayview	17,812	20	21.6	16,730	4	9.4	17,244	65	100.3
	B			-1.63	-$21,297		-5.43	-$65,435		-35.30	-$201,959
210030	A	Chester River	3,047	5	3.1	2,748	0	1.0	2,934	16	15.9
	B			1.89	$24,695		-1.03	-$12,412		0.09	$515
210032	A	Union of Cecil 0907	7,406	11	7.6	6,927	1	3.3	6,955	43	36.1
	B			3.38	$44,163		-2.34	-$28,198		6.95	$39,762
210033	A	Carroll	14,002	11	14.8	12,521	1	5.4	13,366	46	70.2
	B			-3.79	-$49,520		-4.36	-$52,541		-24.15	-$138,167
210034	A	Harbor	11,676	12	13.4	10,899	7	6.0	11,155	69	68.5
	B			-1.39	-$18,162		1.03	$12,412		0.50	$2,861
210035	A	Civista 0807	6,674	3	6.1	6,242	3	2.4	6,208	64	27.1
	B			-3.11	-$40,635		0.61	$7,351		36.87	$210,941
210037	A	Easton	8,026	6	9.6	7,425	1	3.1	7,762	31	41.6
	B			-3.63	-$47,429		-2.10	-$25,306		-10.64	-$60,874
210038	A	Maryland General	9,536	7	13.6	8,622	0	4.8	8,867	62	45.5
	B			-6.64	-$86,758		-4.80	-$57,843		16.51	$94,457
210039	A	Calvert	7,006	6	5.7	6,583	0	2.2	6,856	18	29.8
	B			0.26	$3,397		-2.24	-$26,993		-11.76	-$67,282
210040	A	Northwest	11,468	13	15.8	10,299	3	6.1	10,731	44	66.2
	B			-2.83	-$36,977		-3.12	-$37,598		-22.15	-$126,725
210043	A	Baltimore Washington	16,154	32	21.8	14,605	8	9.2	15,264	110	108.0
	B			10.25	$133,926		-1.18	-$14,220		2.00	$11,442
210044	A	GBMC	18,586	14	19.9	17,222	7	9.0	17,992	71	108.3
	B			-5.85	-$76,436		-2.03	-$24,463		-37.26	-$213,173
210045	A	McCready	652	0	0.6	564	0	0.2	621	1	3.4
	B			-0.61	-$7,970		-0.17	-$2,049		-2.43	-$13,903
210048	A	Howard	11,577	15	12.0	10,560	3	5.1	10,635	158	52.2
	B			3.03	$39,590		-2.06	-$24,824		105.82	$605,419
210049	A	Upper Chesapeake	13,486	19	14.7	12,323	13	5.5	12,685	53	59.9
	B			4.28	$55,922		7.46	$89,897		-6.88	-$39,362
210051	A	Doctors	10,170	30	12.5	9,084	8	4.1	9,401	83	50.3
	B			17.51	$228,784		3.89	$46,877		32.66	$186,855
210054	A	Southern Maryland	15,311	20	16.4	14,160	10	6.1	14,719	51	66.6
	B			3.58	$46,776		3.87	$46,636		-15.60	-$89,251
210055	A	Laurel	5,960	3	6.8	5,180	5	1.9	5,442	42	21.0
	B			-3.81	-$49,781		3.07	$36,995		21.01	$120,203
210056	A	Good Samaritan	15,126	22	27.9	13,978	5	9.7	14,332	46	95.4
	B			-5.88	-$76,828		-4.74	-$57,120		-49.36	-$282,399
210058	A	Kernan	2,339	4	6.8	2,153	0	0.7	2,188	5	7.0
	B			-2.83	-$36,977		-0.65	-$7,833		-2.04	-$11,671
210061	A	Atlantic General	3,137	11	4.0	2,833	5	1.9	2,900	41	19.3
	B			7.01	$91,592		3.11	$37,477		21.75	$124,436
210904	A	Hopkins Oncology	821	1	1.9	799	2	1.4	798	23	12.8
	B			-0.89	-$11,629		0.60	$7,230		10.24	$58,585
		Total	516,332	741		476,063	267		491,768	3,828	

...ses per APR-DRG and Severity

PPC

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 4			PPC 5			PPC 6		
			$20,064			$13,561			$10,500		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	12,813	41	36.2	10,331	136	70.3	12,283	20	30.7
	B			4.82	$96,711		65.74	$891,495		-10.71	-$112,453
210002	A	University Hospital	22,186	205	123.8	19,038	185	165.9	20,471	59	58.0
	B			81.22	$1,629,637		19.09	$258,678		0.98	$10,290
210003	A	Prince Georges	11,030	50	18.6	9,950	110	42.4	9,874	37	14.6
	B			31.41	$630,225		67.57	$916,312		22.37	$234,881
210004	A	Holy Cross	21,346	45	36.9	19,153	86	83.8	20,708	47	32.8
	B			8.15	$163,526		2.20	$29,834		14.17	$148,783
210005	A	Frederick	14,439	33	40.2	11,934	77	73.2	13,737	36	32.2
	B			-7.21	-$144,665		3.82	$51,803		3.76	$39,479
210006	A	Harford	6,320	13	11.2	5,049	24	24.0	5,914	12	10.4
	B			1.79	$35,915		0.02	$271		1.56	$16,380
210007	A	St. Joseph	20,002	50	80.3	17,343	47	128.0	19,530	32	44.2
	B			-30.27	-$607,352		-81.02	-$1,098,706		-12.16	-$127,678
210008	A	Mercy	14,910	21	34.2	12,238	35	66.0	14,347	21	24.7
	B			-13.17	-$264,249		-30.98	-$420,118		-3.66	-$38,429
210009	A	Hopkins Hospital	27,076	144	151.6	23,190	219	205.2	25,786	70	71.3
	B			-7.60	-$152,490		13.85	$187,819		-1.27	-$13,335
210010	A	Dorchester	3,037	6	7.6	2,431	16	14.4	2,809	11	5.7
	B			-1.57	-$31,501		1.64	$22,240		5.32	$55,859
210011	A	St. Agnes	15,641	62	48.3	12,696	80	86.4	14,898	39	36.7
	B			13.73	$275,485		-6.43	-$87,197		2.32	$24,360
210012	A	Sinai	19,826	109	75.2	17,204	118	126.3	18,581	47	49.2
	B			33.84	$678,982		-8.31	-$112,691		-2.23	-$23,415
210013	A	Bon Secours	5,225	13	14.6	4,135	18	25.7	4,740	9	11.5
	B			-1.60	-$32,103		-7.65	-$103,741		-2.50	-$26,250
210015	A	Franklin Square	22,072	40	60.7	17,364	71	106.5	21,234	32	47.6
	B			-20.74	-$416,137		-35.50	-$481,413		-15.62	-$164,007
210017	A	Garrett	2,116	4	4.1	1,838	13	11.1	2,143	2	4.4
	B			-0.09	-$1,806		1.90	$25,766		-2.35	-$24,675
210019	A	Peninsula Regional	16,502	40	76.8	13,850	135	114.9	15,903	30	45.9
	B			-36.83	-$738,975		20.11	$272,710		-15.86	-$166,527
210023	A	Anne Arundel	18,738	32	46.2	16,243	121	89.0	18,278	46	38.1
	B			-14.23	-$285,518		32.01	$434,085		7.87	$82,634
210024	A	Union Memorial	17,824	92	88.0	14,784	87	129.8	16,977	23	41.7
	B			3.97	$79,656		-42.75	-$579,730		-18.66	-$195,927
210025	A	Cumberland	6,224	15	10.9	5,456	20	31.7	5,868	18	10.8
	B			4.12	$82,666		-11.69	-$158,527		7.22	$75,809
210027	A	Sacred Heart	7,075	20	21.1	6,105	32	42.0	7,006	6	13.3
	B			-1.10	-$22,071		-9.97	-$135,202		-7.34	-$77,069
210028	A	St. Mary's	8,311	6	14.0	6,673	25	29.8	7,888	4	11.1
	B			-8.00	-$160,516		-4.82	-$65,364		-7.13	-$74,864
210029	A	Hopkins Bayview	17,244	36	49.9	14,062	87	88.5	16,349	33	38.3
	B			-13.89	-$278,696		-1.53	-$20,748		-5.33	-$55,964
210030	A	Chester River	2,934	8	7.0	2,392	23	14.8	2,784	9	5.3
	B			1.04	$20,867		8.21	$111,335		3.70	$38,849
210032	A	Union of Cecil 0907	6,955	16	16.8	5,247	32	31.3	6,756	13	14.3
	B			-0.81	-$16,252		0.72	$9,764		-1.26	-$13,230
210033	A	Carroll	13,366	27	32.4	10,773	39	60.1	12,337	22	26.1
	B			-5.35	-$107,345		-21.12	-$286,407		-4.10	-$43,049
210034	A	Harbor	11,155	31	32.5	8,634	24	55.3	10,701	16	24.4
	B			-1.47	-$29,495		-31.33	-$424,864		-8.38	-$87,989
210035	A	Civista 0807	6,208	9	12.1	5,273	52	28.0	6,155	7	11.3
	B			-3.11	-$62,401		24.01	$325,598		-4.28	-$44,939
210037	A	Easton	7,762	14	18.6	6,408	36	39.3	7,402	8	15.7
	B			-4.56	-$91,494		-3.31	-$44,887		-7.69	-$80,744
210038	A	Maryland General	8,867	10	24.6	7,197	46	44.8	7,949	20	18.9
	B			-14.55	-$291,938		1.18	$16,002		1.14	$11,970
210039	A	Calvert	6,856	9	14.0	5,644	40	28.0	6,491	17	10.7
	B			-4.95	-$99,319		12.05	$163,409		6.30	$66,149
210040	A	Northwest	10,731	38	33.3	8,780	46	63.3	9,975	30	25.0
	B			4.69	$94,102		-17.30	-$234,604		5.05	$53,024
210043	A	Baltimore Washington	15,264	67	48.0	12,020	94	90.5	14,361	45	39.0
	B			18.96	$380,423		3.46	$46,921		6.00	$62,999
210044	A	GBMC	17,992	37	51.5	15,393	68	95.5	17,112	52	37.1
	B			-14.50	-$290,935		-27.46	-$372,383		14.87	$156,132
210045	A	McCready	621	0	1.3	454	3	2.9	549	1	1.0
	B			-1.31	-$26,284		0.09	$1,220		0.05	$525
210048	A	Howard	10,635	26	24.2	9,237	80	46.9	10,511	30	21.4
	B			1.78	$35,715		33.15	$449,545		8.63	$90,614
210049	A	Upper Chesapeake	12,685	33	26.6	10,527	42	56.6	12,208	18	24.3
	B			6.45	$129,416		-14.60	-$197,990		-6.26	-$65,729
210051	A	Doctors	9,401	35	24.0	7,625	121	53.3	8,895	36	18.6
	B			10.98	$220,308		67.68	$917,804		17.36	$182,277
210054	A	Southern Maryland	14,719	31	31.2	12,529	35	67.2	13,928	25	27.0
	B			-0.15	-$3,010		-32.17	-$436,255		-1.95	-$20,475
210055	A	Laurel	5,442	15	9.8	4,662	61	21.6	5,078	20	8.9
	B			5.25	$105,339		39.38	$534,029		11.09	$118,443
210056	A	Good Samaritan	14,332	29	45.9	11,403	60	93.1	13,504	36	39.1
	B			-16.92	-$339,491		-33.12	-$449,138		-3.10	-$32,549
210058	A	Kernan	2,188	0	1.9	2,022	8	13.7	2,172	8	6.0
	B			-1.89	-$37,922		-5.70	-$77,297		2.04	$21,420
210061	A	Atlantic General	2,900	9	9.3	2,404	30	19.0	2,930	10	9.4
	B			-0.30	-$6,019		10.97	$148,763		0.56	$5,880
210904	A	Hopkins Oncology	798	0	6.1	689	6	8.1	780	2	2.5
	B			-6.05	-$121,390		-2.12	-$28,749		-0.50	-$5,250
		Total	491,768	1,521		410,380	2,686		467,902	1,059	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 7			PPC 8			PPC 9		
			$10,735			$7,791			$11,109		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	13,854	24	15.4	7,759	45	26.2	13,586	24	32.3
	B			8.65	$92,854		18.84	$146,787		-8.34	-$92,652
210002	A	University Hospital	22,905	32	27.0	15,071	231	127.4	22,898	127	121.8
	B			4.97	$53,351		103.60	$807,174		5.16	$57,324
210003	A	Prince Georges	11,599	14	7.7	8,131	16	17.8	11,246	24	17.5
	B			6.27	$67,306		-1.76	-$13,713		6.55	$72,766
210004	A	Holy Cross	22,860	17	19.0	16,628	37	42.1	21,782	35	32.7
	B			-1.96	-$21,040		-5.12	-$39,891		2.31	$25,663
210005	A	Frederick	15,387	22	15.3	9,108	32	27.3	15,052	35	33.9
	B			6.72	$72,136		4.74	$36,931		1.15	$12,776
210006	A	Harford	6,767	2	5.0	3,845	7	9.2	6,545	11	9.1
	B			-2.99	-$32,096		-2.15	-$16,751		1.87	$20,774
210007	A	St. Joseph	20,740	12	24.1	13,434	95	119.8	20,484	140	103.9
	B			-12.10	-$129,889		-24.75	-$192,833		36.09	$400,936
210008	A	Mercy	15,171	11	15.6	9,915	21	31.9	15,232	3	29.0
	B			-4.59	-$49,272		-10.94	-$85,236		-25.97	-$288,509
210009	A	Hopkins Hospital	27,843	44	36.8	18,135	111	160.4	28,076	211	155.0
	B			7.23	$77,611		-49.42	-$385,044		56.02	$622,345
210010	A	Dorchester	3,142	5	2.3	1,729	7	4.9	3,132	6	5.8
	B			2.66	$28,554		2.08	$16,206		0.23	$2,555
210011	A	St. Agnes	16,465	13	18.7	9,573	28	34.1	16,204	66	43.8
	B			-5.69	-$61,080		-6.12	-$47,682		22.16	$246,183
210012	A	Sinai	20,898	25	28.4	13,390	132	90.0	20,387	41	75.1
	B			-3.38	-$36,283		42.04	$327,544		-34.08	-$378,606
210013	A	Bon Secours	5,758	5	5.6	2,959	6	8.8	5,466	9	13.6
	B			-0.58	-$6,226		-2.80	-$21,816		-4.63	-$51,436
210015	A	Franklin Square	23,514	10	21.6	13,022	25	40.2	22,762	44	51.4
	B			-11.58	-$124,307		-15.23	-$118,661		-7.36	-$81,765
210017	A	Garrett	2,380	1	2.5	1,412	2	4.2	2,310	0	3.8
	B			-1.54	-$16,531		-2.19	-$17,063		-3.81	-$42,327
210019	A	Peninsula Regional	17,881	12	23.6	10,031	57	65.7	17,147	116	96.6
	B			-11.57	-$124,199		-8.69	-$67,706		19.36	$215,077
210023	A	Anne Arundel	20,069	20	21.0	13,906	39	43.7	19,267	39	39.0
	B			-0.96	-$10,305		-4.72	-$36,775		0.03	$333
210024	A	Union Memorial	18,290	23	24.7	10,384	105	113.6	18,175	95	116.9
	B			-1.74	-$18,678		-8.61	-$67,083		-21.89	-$243,183
210025	A	Cumberland	6,691	8	6.7	4,169	10	11.2	6,606	8	8.6
	B			1.30	$13,955		-1.15	-$8,960		-0.80	-$8,887
210027	A	Sacred Heart	8,214	5	6.9	4,096	32	35.1	8,009	9	30.9
	B			-1.91	-$20,503		-3.11	-$24,231		-21.85	-$242,739
210028	A	St. Mary's	8,558	6	5.3	5,329	5	12.6	8,505	3	11.2
	B			0.68	$7,300		-7.55	-$58,824		-8.17	-$90,763
210029	A	Hopkins Bayview	18,036	25	18.3	10,675	44	32.2	17,821	31	42.9
	B			6.74	$72,351		11.84	$92,248		-11.92	-$132,423
210030	A	Chester River	3,089	9	2.8	1,760	14	6.0	3,014	0	5.5
	B			6.19	$66,447		8.02	$62,486		-5.50	-$61,101
210032	A	Union of Cecil 0907	7,475	1	6.0	3,975	4	11.4	7,346	7	15.9
	B			-5.01	-$53,780		-7.39	-$57,577		-8.90	-$98,873
210033	A	Carroll	14,098	12	13.0	8,140	12	22.4	13,902	24	28.4
	B			-0.98	-$10,520		-10.44	-$81,341		-4.40	-$48,881
210034	A	Harbor	11,713	3	11.5	6,175	8	18.3	11,555	12	26.0
	B			-8.47	-$90,922		-10.30	-$80,250		-14.01	-$155,642
210035	A	Civista 0807	6,698	8	5.7	4,091	11	10.0	6,588	19	12.0
	B			2.27	$24,368		1.05	$8,181		7.01	$77,876
210037	A	Easton	8,158	10	8.2	4,797	26	15.1	8,120	9	15.3
	B			1.79	$19,215		10.91	$85,003		-6.29	-$69,876
210038	A	Maryland General	9,502	7	9.4	5,168	11	14.4	9,179	19	21.9
	B			-2.36	-$25,334		-3.40	-$26,490		-2.88	-$31,995
210039	A	Calvert	7,039	6	4.7	4,468	16	10.7	7,005	3	10.8
	B			1.28	$13,740		5.34	$41,605		-7.76	-$86,208
210040	A	Northwest	11,505	14	12.1	6,226	12	23.4	11,151	21	28.1
	B			1.93	$20,718		-11.37	-$88,587		-7.08	-$78,654
210043	A	Baltimore Washington	16,434	18	18.9	8,357	25	33.6	16,038	38	43.2
	B			-0.92	-$9,876		-8.57	-$66,771		-5.20	-$57,769
210044	A	GBMC	18,691	15	18.8	12,682	41	44.0	18,521	41	43.2
	B			-3.75	-$40,255		-2.99	-$23,296		-2.24	-$24,885
210045	A	McCready	658	2	0.6	280	2	0.9	637	0	0.9
	B			1.44	$15,458		1.11	$8,648		-0.92	-$10,221
210048	A	Howard	11,597	12	10.0	7,801	25	22.8	11,211	55	23.4
	B			1.98	$21,254		2.22	$17,297		31.61	$351,166
210049	A	Upper Chesapeake	13,530	15	11.6	8,381	25	24.3	13,178	26	24.5
	B			3.43	$36,820		0.75	$5,843		1.48	$16,442
210051	A	Doctors	9,946	24	11.1	5,638	45	20.2	9,701	29	19.3
	B			12.95	$139,013		24.83	$193,457		9.71	$107,872
210054	A	Southern Maryland	15,532	10	12.4	9,603	9	25.7	15,391	45	31.6
	B			-2.39	-$25,656		-16.70	-$130,114		13.37	$148,532
210055	A	Laurel	5,932	8	5.6	3,736	9	9.0	5,642	25	8.9
	B			2.45	$26,300		-0.03	-$234		16.13	$179,194
210056	A	Good Samaritan	15,241	23	21.9	7,497	16	32.0	14,923	29	40.5
	B			1.15	$12,345		-15.97	-$124,426		-11.48	-$127,535
210058	A	Kernan	2,359	6	6.7	1,576	6	7.3	2,340	1	1.7
	B			-0.73	-$7,836		-1.31	-$10,207		-0.72	-$7,999
210061	A	Atlantic General	3,260	5	4.2	1,753	12	7.8	3,197	5	8.7
	B			0.83	$8,910		4.23	$32,957		-3.70	-$41,105
210904	A	Hopkins Oncology	814	4	1.7	599	6	4.8	811	3	3.3
	B			2.28	$24,475		1.17	$9,116		-0.32	-$3,555
		Total	520,293	548		315,404	1,422		510,142	1,488	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 10			PPC 11			PPC 12		
				$3,895			$5,643			$2,418	
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	11,724	70	51.5	13,846	66	44.7	0	0	0.0
	B			18.51	$72,092		21.35	$120,473		0.00	$0
210002	A	University Hospital	20,802	81	115.3	22,710	60	69.0	406	96	126.6
	B			-34.34	-$133,746		-8.98	-$50,672		-30.57	-$73,907
210003	A	Prince Georges	9,889	10	25.6	11,521	59	26.2	29	2	7.9
	B			-15.58	-$60,680		32.79	$185,026		-5.91	-$14,288
210004	A	Holy Cross	21,270	72	63.9	22,998	53	51.6	0	0	0.0
	B			8.10	$31,548		1.38	$7,787		0.00	$0
210005	A	Frederick	13,258	95	56.6	15,318	57	46.5	0	0	0.0
	B			38.38	$149,481		10.49	$59,193		0.00	$0
210006	A	Harford	5,838	22	20.1	6,730	30	15.3	0	0	0.0
	B			1.92	$7,478		14.69	$82,892		0.00	$0
210007	A	St. Joseph	17,896	102	122.0	19,996	55	74.8	469	158	140.2
	B			-19.99	-$77,856		-19.82	-$111,840		17.82	$43,082
210008	A	Mercy	13,824	5	41.0	15,334	17	35.6	0	0	0.0
	B			-35.97	-$140,095		-18.61	-$105,012		0.00	$0
210009	A	Hopkins Hospital	25,147	49	136.6	28,111	40	84.7	408	120	127.9
	B			-87.63	-$341,298		-44.66	-$252,006		-7.91	-$19,123
210010	A	Dorchester	2,531	36	9.6	3,137	5	7.6	0	0	0.0
	B			26.40	$102,822		-2.64	-$14,897		0.00	$0
210011	A	St. Agnes	13,872	28	59.8	16,463	51	55.1	0	0	0.0
	B			-31.80	-$123,853		-4.12	-$23,248		0.00	$0
210012	A	Sinai	18,307	75	97.7	20,625	71	67.9	231	57	65.3
	B			-22.67	-$88,294		3.11	$17,549		-8.25	-$19,945
210013	A	Bon Secours	4,651	0	21.2	5,775	16	20.5	0	0	0.0
	B			-21.16	-$82,413		-4.51	-$25,449		0.00	$0
210015	A	Franklin Square	19,948	68	79.8	23,300	94	67.5	0	0	0.0
	B			-11.81	-$45,997		26.47	$149,364		0.00	$0
210017	A	Garrett	2,066	20	8.0	2,339	7	6.8	0	0	0.0
	B			11.99	$46,698		0.24	$1,354		0.00	$0
210019	A	Peninsula Regional	14,045	167	95.6	17,312	52	74.6	284	82	85.0
	B			71.42	$278,164		-22.60	-$127,527		-3.03	-$7,325
210023	A	Anne Arundel	18,073	37	64.7	19,967	53	55.6	0	0	0.0
	B			-27.65	-$107,690		-2.63	-$14,840		0.00	$0
210024	A	Union Memorial	14,897	154	115.0	17,534	44	66.4	568	228	170.7
	B			38.97	$151,779		-22.36	-$126,172		57.31	$138,554
210025	A	Cumberland	5,873	36	19.1	6,658	22	15.0	0	0	0.0
	B			16.94	$65,977		6.99	$39,443		0.00	$0
210027	A	Sacred Heart	6,430	26	40.0	8,014	16	24.1	165	31	50.2
	B			-14.00	-$54,527		-8.12	-$45,819		-19.21	-$46,443
210028	A	St. Mary's	7,332	8	20.5	8,570	21	17.2	0	0	0.0
	B			-12.46	-$48,529		3.85	$21,725		0.00	$0
210029	A	Hopkins Bayview	15,261	38	56.7	17,922	47	50.6	0	0	0.0
	B			-18.71	-$72,871		-3.57	-$20,145		0.00	$0
210030	A	Chester River	2,724	145	12.3	3,073	13	8.4	0	0	0.0
	B			132.66	$516,679		4.65	$26,239		0.00	$0
210032	A	Union of Cecil 0907	6,268	15	25.9	7,398	31	20.2	0	0	0.0
	B			-10.88	-$42,375		10.81	$60,998		0.00	$0
210033	A	Carroll	12,003	35	45.8	13,985	60	36.3	0	0	0.0
	B			-10.84	-$42,219		23.67	$133,564		0.00	$0
210034	A	Harbor	9,836	17	39.0	11,740	26	33.8	0	0	0.0
	B			-22.02	-$85,763		-7.77	-$43,844		0.00	$0
210035	A	Civista 0807	5,699	11	20.0	6,707	20	18.1	0	0	0.0
	B			-8.98	-$34,975		1.87	$10,552		0.00	$0
210037	A	Easton	6,840	56	25.4	8,058	20	20.2	0	0	0.0
	B			30.65	$119,374		-0.21	-$1,185		0.00	$0
210038	A	Maryland General	8,011	24	33.5	9,618	12	31.8	0	0	0.0
	B			-9.49	-$36,961		-19.81	-$111,783		0.00	$0
210039	A	Calvert	6,257	35	20.8	6,987	15	14.7	0	0	0.0
	B			14.16	$55,150		0.33	$1,862		0.00	$0
210040	A	Northwest	9,356	45	46.9	11,522	27	42.0	0	0	0.0
	B			-1.93	-$7,517		-14.95	-$84,359		0.00	$0
210043	A	Baltimore Washington	13,358	90	64.8	16,208	60	55.2	0	0	0.0
	B			25.21	$98,187		4.81	$27,142		0.00	$0
210044	A	GBMC	16,940	74	59.1	18,830	48	48.8	0	0	0.0
	B			14.92	$58,110		-0.81	-$4,571		0.00	$0
210045	A	McCready	516	0	2.2	654	1	1.7	0	0	0.0
	B			-2.24	-$8,724		-0.72	-$4,063		0.00	$0
210048	A	Howard	10,473	47	38.2	11,609	37	32.8	0	0	0.0
	B			8.79	$34,235		4.22	$23,812		0.00	$0
210049	A	Upper Chesapeake	11,985	49	46.7	13,455	71	35.5	1	0	0.1
	B			2.30	$8,958		35.52	$200,431		-0.14	-$338
210051	A	Doctors	8,413	44	36.0	10,257	40	33.2	0	0	0.0
	B			8.00	$31,158		6.83	$38,540		0.00	$0
210054	A	Southern Maryland	12,858	24	46.1	15,451	37	41.9	1	0	0.1
	B			-22.13	-$86,191		-4.85	-$27,367		-0.11	-$266
210055	A	Laurel	5,139	1	18.7	5,968	24	16.2	0	0	0.0
	B			-17.67	-$68,820		7.79	$43,957		0.00	$0
210056	A	Good Samaritan	11,970	38	58.0	15,257	55	55.4	0	0	0.0
	B			-20.03	-$78,012		-0.41	-$2,314		0.00	$0
210058	A	Kernan	2,239	1	8.3	2,403	0	5.5	0	0	0.0
	B			-7.30	-$28,432		-5.47	-$30,866		0.00	$0
210061	A	Atlantic General	2,631	34	14.3	3,254	11	13.0	0	0	0.0
	B			19.72	$76,805		-2.01	-$11,342		0.00	$0
210904	A	Hopkins Oncology	787	2	3.8	818	0	2.3	0	0	0.0
	B			-1.76	-$6,855		-2.25	-$12,696		0.00	$0
		Total	447,237	1,986		517,432	1,544		2,562	774	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 13			PPC 14			PPC 15		
			$3,197			$15,459			$12,992		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	12,678	18	11.1	13,996	30	40.1	13,952	6	6.3
	B			6.94	$22,189		-10.10	-$156,136		-0.30	-$3,898
210002	A	University Hospital	21,067	21	31.8	23,248	91	84.4	23,070	26	18.3
	B			-10.80	-$34,530		6.56	$101,411		7.71	$100,168
210003	A	Prince Georges	10,603	92	14.8	11,762	54	27.3	11,709	17	4.8
	B			77.16	$246,696		26.74	$413,373		12.21	$158,632
210004	A	Holy Cross	22,210	9	12.8	23,270	65	50.7	23,224	5	7.8
	B			-3.81	-$12,181		14.30	$221,063		-2.78	-$36,118
210005	A	Frederick	13,882	6	12.0	15,596	20	42.6	15,549	5	6.4
	B			-6.01	-$19,215		-22.63	-$349,837		-1.44	-$18,708
210006	A	Harford	5,791	4	4.7	6,835	19	14.5	6,828	0	1.7
	B			-0.72	-$2,302		4.50	$69,565		-1.71	-$22,216
210007	A	St. Joseph	17,635	18	41.4	20,979	94	84.1	20,914	10	14.3
	B			-23.39	-$74,782		9.88	$152,735		-4.25	-$55,216
210008	A	Mercy	13,880	6	10.2	15,401	14	28.2	15,295	5	10.3
	B			-4.22	-$13,492		-14.21	-$219,672		-5.28	-$68,597
210009	A	Hopkins Hospital	26,170	11	32.8	28,602	87	106.0	28,410	26	22.2
	B			-21.83	-$69,795		-18.96	-$293,102		3.79	$49,239
210010	A	Dorchester	2,864	7	2.5	3,184	14	7.0	3,178	3	0.8
	B			4.47	$14,291		7.05	$108,986		2.18	$28,322
210011	A	St. Agnes	14,924	12	14.1	16,716	47	52.2	16,608	9	10.9
	B			-2.12	-$6,778		-5.22	-$80,696		-1.94	-$25,204
210012	A	Sinai	18,865	21	25.0	21,170	120	75.2	21,100	10	11.5
	B			-4.01	-$12,821		44.76	$691,944		-1.50	-$19,488
210013	A	Bon Secours	5,276	22	5.2	5,868	19	21.4	5,853	6	3.2
	B			16.82	$53,777		-2.37	-$36,638		2.76	$35,858
210015	A	Franklin Square	20,701	9	20.7	23,749	39	63.0	23,586	8	14.7
	B			-11.73	-$37,503		-24.04	-$371,634		-6.70	-$87,046
210017	A	Garrett	2,100	4	1.9	2,398	6	5.3	2,394	0	0.9
	B			2.14	$6,842		0.69	$10,667		-0.93	-$12,083
210019	A	Peninsula Regional	15,295	15	26.3	18,090	68	90.7	17,914	10	14.4
	B			-11.27	-$36,032		-22.65	-$350,146		-4.38	-$56,905
210023	A	Anne Arundel	19,361	14	15.5	20,291	24	48.2	20,231	10	10.8
	B			-1.53	-$4,892		-24.21	-$374,262		-0.77	-$10,004
210024	A	Union Memorial	14,934	31	38.4	18,475	93	85.1	18,273	20	15.3
	B			-7.38	-$23,595		7.92	$122,435		4.72	$61,322
210025	A	Cumberland	6,225	11	5.0	6,723	20	11.8	6,706	4	2.1
	B			5.99	$19,151		8.16	$126,145		1.88	$24,425
210027	A	Sacred Heart	6,435	9	11.3	8,263	29	30.8	8,238	6	4.1
	B			-2.25	-$7,194		-1.76	-$27,208		1.88	$24,425
210028	A	St. Mary's	7,231	4	6.1	8,650	1	13.9	8,632	1	2.2
	B			-2.05	-$6,554		-12.94	-$200,039		-1.19	-$15,460
210029	A	Hopkins Bayview	16,865	8	14.3	18,222	32	49.4	18,103	10	9.5
	B			-6.28	-$20,078		-17.38	-$268,677		0.47	$6,106
210030	A	Chester River	2,841	4	2.8	3,115	14	6.6	3,100	1	1.4
	B			1.22	$3,901		7.38	$114,087		-0.40	-$5,197
210032	A	Union of Cecil 0907	6,802	3	8.4	7,535	34	18.9	7,511	1	2.8
	B			-5.39	-$17,233		15.08	$233,121		-1.81	-$23,515
210033	A	Carroll	12,562	3	12.3	14,241	19	34.5	14,185	3	5.6
	B			-9.25	-$29,574		-15.51	-$239,769		-2.61	-$33,909
210034	A	Harbor	10,061	5	8.6	11,885	30	31.3	11,851	3	4.5
	B			-3.56	-$11,382		-1.28	-$19,787		-1.49	-$19,358
210035	A	Civista 0807	6,154	17	6.8	6,782	16	15.7	6,771	11	3.0
	B			10.22	$32,675		0.27	$4,174		8.01	$104,066
210037	A	Easton	7,471	7	7.3	8,231	23	19.1	8,208	2	3.1
	B			-0.29	-$927		3.87	$59,826		-1.14	-$14,811
210038	A	Maryland General	8,774	6	7.7	9,688	22	30.5	9,648	0	4.7
	B			-1.72	-$5,499		-8.52	-$131,710		-4.66	-$60,542
210039	A	Calvert	6,183	11	6.1	7,114	7	13.9	7,107	2	1.8
	B			4.88	$15,602		-6.89	-$106,512		0.23	$2,988
210040	A	Northwest	10,512	2	12.3	11,725	52	39.4	11,687	5	5.4
	B			-10.27	-$32,835		12.65	$195,556		-0.42	-$5,457
210043	A	Baltimore Washington	14,992	18	15.9	16,641	70	50.4	16,479	6	8.9
	B			2.07	$6,618		19.62	$303,305		-2.85	-$37,027
210044	A	GBMC	18,127	17	12.1	18,927	28	41.4	18,861	3	9.3
	B			4.92	$15,730		-13.38	-$206,841		-6.31	-$81,979
210045	A	McCready	582	1	1.9	667	0	1.4	665	0	0.2
	B			-0.85	-$2,718		-1.35	-$20,870		-0.21	-$2,728
210048	A	Howard	11,421	5	8.3	11,803	32	30.9	11,782	1	4.6
	B			-3.27	-$10,455		1.09	$16,850		-3.60	-$46,771
210049	A	Upper Chesapeake	11,847	13	11.3	13,726	46	32.6	13,684	7	6.8
	B			1.68	$5,371		13.44	$207,769		0.19	$2,468
210051	A	Doctors	9,315	22	10.8	10,385	52	28.6	10,362	9	6.3
	B			11.22	$35,873		23.39	$361,585		2.67	$34,689
210054	A	Southern Maryland	13,022	4	12.7	15,782	74	40.6	15,715	11	8.1
	B			-8.72	-$27,880		33.38	$516,021		2.92	$37,936
210055	A	Laurel	5,477	33	8.2	6,095	11	16.1	6,068	15	2.3
	B			24.80	$79,290		-5.11	-$78,995		12.67	$164,608
210056	A	Good Samaritan	13,459	4	18.5	15,468	26	50.7	15,396	2	9.4
	B			-14.46	-$46,231		-24.68	-$381,527		-7.41	-$96,270
210058	A	Kernan	2,371	2	2.9	2,408	1	6.4	2,403	0	0.9
	B			-0.93	-$2,973		-5.38	-$83,169		-0.87	-$11,303
210061	A	Atlantic General	2,890	6	2.9	3,304	11	10.8	3,292	4	1.8
	B			3.06	$9,783		0.23	$3,556		2.18	$28,322
210904	A	Hopkins Oncology	815	1	0.5	821	0	2.4	818	1	0.5
	B			0.52	$1,663		-2.35	-$36,329		0.51	$6,626
		Total	470,680	536		527,831	1,554		525,360	284	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 16			PPC 17			PPC 18		
				$10,758			$11,231			$14,354	
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	13,855	38	33.2	13,246	25	18.8	13,217	17	7.0
	B			4.85	$52,174		6.17	$69,294		9.96	$142,967
210002	A	University Hospital	22,944	101	77.4	22,655	36	37.4	22,489	8	10.0
	B			23.62	$254,095		-1.36	-$15,274		-1.98	-$28,421
210003	A	Prince Georges	11,641	36	19.5	11,401	38	12.1	11,298	13	4.8
	B			16.49	$177,393		25.93	$291,213		8.21	$117,847
210004	A	Holy Cross	23,058	32	39.2	22,235	18	23.0	21,995	6	8.9
	B			-7.16	-$77,025		-5.02	-$56,378		-2.86	-$41,053
210005	A	Frederick	15,404	29	32.4	14,662	9	19.6	14,607	8	7.9
	B			-3.38	-$36,361		-10.57	-$118,709		0.08	$1,148
210006	A	Harford	6,787	4	10.3	6,501	19	8.5	6,470	1	2.5
	B			-6.33	-$68,096		10.51	$118,035		-1.48	-$21,244
210007	A	St. Joseph	20,802	50	69.4	20,049	28	34.7	19,944	6	9.0
	B			-19.35	-$208,160		-6.73	-$75,583		-2.95	-$42,345
210008	A	Mercy	15,265	36	30.3	14,800	11	16.5	14,648	2	5.1
	B			5.70	$61,318		-5.47	-$61,432		-3.10	-$44,498
210009	A	Hopkins Hospital	28,179	112	97.8	27,627	36	44.5	27,084	7	11.7
	B			14.25	$153,296		-8.52	-$95,686		-4.73	-$67,895
210010	A	Dorchester	3,153	4	5.0	2,995	1	3.8	2,980	2	1.4
	B			-0.98	-$10,542		-2.76	-$30,997		0.57	$8,182
210011	A	St. Agnes	16,476	41	41.0	15,705	22	24.5	15,625	16	9.1
	B			-0.03	-$323		-2.51	-$28,189		6.94	$99,617
210012	A	Sinai	20,987	59	65.2	20,385	48	33.8	20,229	8	10.1
	B			-6.21	-$66,805		14.23	$159,814		-2.08	-$29,857
210013	A	Bon Secours	5,801	12	14.2	5,555	7	8.9	5,491	3	3.6
	B			-2.22	-$23,882		-1.89	-$21,226		-0.60	-$8,612
210015	A	Franklin Square	23,545	33	50.7	22,584	13	30.4	22,500	8	10.4
	B			-17.72	-$190,625		-17.41	-$195,527		-2.37	-$34,019
210017	A	Garrett	2,374	1	4.7	2,239	1	3.0	2,239	1	1.1
	B			-3.67	-$39,480		-2.01	-$22,574		-0.05	-$718
210019	A	Pennisula Regional	17,864	49	62.4	17,243	23	34.4	17,173	3	10.8
	B			-13.35	-$143,614		-11.42	-$128,255		-7.76	-$111,388
210023	A	Anne Arundel	20,088	28	45.2	19,345	21	24.1	19,280	8	9.1
	B			-17.15	-$184,493		-3.12	-$35,040		-1.06	-$15,215
210024	A	Union Memorial	18,306	117	70.0	17,872	34	34.1	17,779	7	8.2
	B			47.03	$505,931		-0.05	-$562		-1.17	-$16,794
210025	A	Cumberland	6,682	14	13.2	6,425	21	7.9	6,421	9	2.6
	B			0.85	$9,144		13.14	$147,572		6.45	$92,584
210027	A	Sacred Heart	8,195	11	19.2	7,761	15	11.5	7,756	6	3.6
	B			-8.21	-$88,320		3.46	$38,858		2.40	$34,450
210028	A	St. Mary's	8,557	8	11.3	8,207	9	8.4	8,183	5	2.7
	B			-3.30	-$35,500		0.64	$7,188		2.33	$33,445
210029	A	Hopkins Bayview	18,010	30	38.4	17,544	17	23.8	17,492	5	9.3
	B			-8.35	-$89,826		-6.77	-$76,032		-4.27	-$61,292
210030	A	Chester River	3,079	14	5.5	2,936	8	3.8	2,929	4	1.3
	B			8.50	$91,440		4.21	$47,281		2.74	$39,330
210032	A	Union of Cecil 0907	7,451	6	13.8	7,090	14	9.6	7,085	6	3.3
	B			-7.79	-$83,802		4.36	$48,966		2.66	$38,182
210033	A	Carroll	14,071	10	26.2	13,392	8	16.7	13,381	3	6.1
	B			-16.15	-$173,736		-8.71	-$97,820		-3.05	-$43,780
210034	A	Harbor	11,755	10	23.4	11,232	14	13.8	11,149	5	5.4
	B			-13.37	-$143,829		0.17	$1,909		-0.36	-$5,167
210035	A	Civista 0807	6,716	14	11.8	6,449	25	8.5	6,405	5	2.8
	B			2.22	$23,882		16.54	$185,757		2.22	$31,866
210037	A	Easton	8,164	8	17.4	7,778	11	10.0	7,758	3	3.2
	B			-9.35	-$100,584		0.98	$11,006		-0.16	-$2,297
210038	A	Maryland General	9,570	6	23.2	9,230	9	13.2	9,105	3	5.4
	B			-17.18	-$184,816		-4.22	-$47,394		-2.38	-$34,163
210039	A	Calvert	7,042	5	9.7	6,699	6	7.4	6,682	1	2.5
	B			-4.71	-$50,668		-1.37	-$15,386		-1.47	-$21,101
210040	A	Northwest	11,561	14	27.0	10,970	15	17.8	10,874	11	7.1
	B			-12.97	-$139,526		-2.81	-$31,558		3.94	$56,555
210043	A	Baltimore Washington	16,435	40	41.7	15,429	22	24.3	15,386	8	8.5
	B			-1.68	-$18,073		-2.27	-$25,494		-0.51	-$7,321
210044	A	GBMC	18,742	32	37.6	17,953	16	22.1	17,857	4	7.3
	B			-5.64	-$60,673		-6.10	-$68,508		-3.26	-$46,794
210045	A	McCready	657	0	0.9	617	1	0.8	617	0	0.3
	B			-0.86	-$9,252		0.21	$2,358		-0.28	-$4,019
210048	A	Howard	11,608	63	22.1	11,193	8	14.3	11,138	4	5.2
	B			40.90	$439,987		-6.32	-$70,978		-1.24	-$17,799
210049	A	Upper Chesapeake	13,552	12	24.2	13,041	17	17.1	12,996	3	6.0
	B			-12.23	-$131,566		-0.07	-$786		-2.96	-$42,488
210051	A	Doctors	10,234	77	24.5	9,688	36	15.3	9,347	17	5.8
	B			52.47	$564,453		20.74	$232,926		11.25	$161,484
210054	A	Southern Maryland	15,622	20	28.9	15,055	19	19.8	14,925	7	7.0
	B			-8.91	-$95,850		-0.83	-$9,322		-0.02	-$287
210055	A	Laurel	5,944	24	12.4	5,745	23	8.2	5,694	1	2.6
	B			11.58	$124,573		14.84	$166,664		-1.59	-$22,823
210056	A	Good Samaritan	15,284	46	51.5	14,675	10	25.5	14,564	5	9.2
	B			-5.50	-$59,167		-15.48	-$173,852		-4.20	-$60,287
210058	A	Kernan	2,350	21	14.9	2,377	5	5.9	2,377	0	0.7
	B			6.07	$65,299		-0.92	-$10,332		-0.66	-$9,474
210061	A	Atlantic General	3,256	6	8.0	3,064	5	5.1	3,057	1	2.0
	B			-2.00	-$21,515		-0.11	-$1,235		-0.96	-$13,780
210904	A	Hopkins Oncology	813	4	2.8	802	0	1.3	799	0	0.2
	B			1.24	$13,339		-1.31	-$14,712		-0.20	-$2,871
		Total	521,879	1,277		502,451	724		499,023	240	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 19			PPC 20			PPC 21		
			$10,045			$8,672			$16,495		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	13,743	11	6.0	13,236	10	8.1	13,996	60	30.2
	B			4.98	$50,025		1.86	$16,130		29.82	$491,867
210002	A	University Hospital	22,865	13	16.0	22,652	31	13.7	23,248	53	54.4
	B			-2.97	-$29,834		17.30	$150,028		-1.39	-$22,927
210003	A	Prince Georges	11,637	4	3.9	11,382	9	3.7	11,762	10	15.7
	B			0.10	$1,005		5.27	$45,702		-5.70	-$94,019
210004	A	Holy Cross	23,058	3	8.3	22,223	12	12.4	23,270	50	36.4
	B			-5.30	-$53,239		-0.44	-$3,816		13.65	$225,150
210005	A	Frederick	15,312	1	6.4	14,672	16	7.9	15,596	44	31.8
	B			-5.42	-$54,445		8.12	$70,418		12.18	$200,903
210006	A	Harford	6,675	2	2.1	6,505	3	2.4	6,835	6	10.2
	B			-0.09	-$904		0.57	$4,943		-4.17	-$68,782
210007	A	St. Joseph	20,762	14	14.8	20,033	8	14.5	20,979	41	39.5
	B			-0.83	-$8,337		-6.47	-$56,109		1.54	$25,402
210008	A	Mercy	15,203	4	5.1	14,768	12	9.4	15,401	13	21.8
	B			-1.08	-$10,849		2.65	$22,981		-8.81	-$145,317
210009	A	Hopkins Hospital	27,925	27	20.0	27,631	27	20.2	28,602	77	69.1
	B			7.04	$70,718		6.77	$58,711		7.92	$130,637
210010	A	Dorchester	3,120	3	1.1	2,997	4	1.3	3,184	0	5.3
	B			1.93	$19,367		2.67	$23,155		-5.32	-$87,751
210011	A	St. Agnes	16,468	10	8.0	15,684	13	10.4	16,716	35	36.4
	B			1.98	$19,889		2.61	$22,634		-1.35	-$22,268
210012	A	Sinai	20,869	13	12.6	20,378	13	12.9	21,170	35	48.2
	B			0.41	$4,118		0.15	$1,301		-13.20	-$217,728
210013	A	Bon Secours	5,726	1	3.3	5,572	0	2.8	5,868	3	15.5
	B			-2.29	-$23,003		-2.78	-$24,109		-12.45	-$205,357
210015	A	Franklin Square	23,332	6	10.3	22,584	10	11.8	23,749	79	45.2
	B			-4.32	-$43,395		-1.75	-$15,176		33.81	$557,680
210017	A	Garrett	2,362	1	0.8	2,236	0	1.5	2,398	1	4.2
	B			0.17	$1,708		-1.54	-$13,355		-3.19	-$52,618
210019	A	Peninsula Regional	17,819	13	14.9	17,192	5	11.9	18,090	58	49.2
	B			-1.91	-$19,186		-6.88	-$59,665		8.77	$144,657
210023	A	Anne Arundel	20,012	9	7.8	19,361	5	11.1	20,291	31	35.4
	B			1.20	$12,054		-6.14	-$53,247		-4.37	-$72,081
210024	A	Union Memorial	18,235	13	14.3	17,868	6	10.6	18,475	30	39.6
	B			-1.33	-$13,360		-4.55	-$39,458		-9.56	-$157,688
210025	A	Cumberland	6,677	3	1.6	6,425	5	2.9	6,723	10	9.7
	B			1.44	$14,465		2.06	$17,865		0.27	$4,454
210027	A	Sacred Heart	8,178	1	4.3	7,772	4	3.6	8,263	4	15.7
	B			-3.32	-$33,350		0.40	$3,469		-11.72	-$193,316
210028	A	St. Mary's	8,553	2	2.4	8,199	5	2.9	8,650	1	10.3
	B			-0.37	-$3,717		2.14	$18,558		-9.29	-$153,234
210029	A	Hopkins Bayview	17,726	15	8.2	17,552	10	8.4	18,222	48	37.4
	B			6.83	$68,606		1.58	$13,702		10.61	$175,007
210030	A	Chester River	3,074	2	1.0	2,934	2	1.5	3,115	4	5.1
	B			1.02	$10,246		0.51	$4,423		-1.05	-$17,319
210032	A	Union of Cecil 0907	7,381	4	3.0	7,097	4	4.0	7,535	6	13.5
	B			1.05	$10,547		0.00	$0		-7.54	-$124,369
210033	A	Carroll	14,024	6	5.1	13,401	3	7.9	14,241	11	24.9
	B			0.90	$9,041		-4.90	-$42,494		-13.90	-$229,274
210034	A	Harbor	11,647	2	5.2	11,245	3	5.8	11,885	25	22.8
	B			-3.17	-$31,843		-2.83	-$24,542		2.17	$35,793
210035	A	Civista 0807	6,696	3	2.3	6,440	0	3.3	6,782	20	11.6
	B			0.75	$7,534		-3.31	-$28,705		8.43	$139,049
210037	A	Easton	8,123	5	2.8	7,779	4	4.2	8,231	12	13.6
	B			2.18	$21,898		-0.22	-$1,908		-1.62	-$26,721
210038	A	Maryland General	9,442	5	4.9	9,231	0	4.2	9,688	16	25.2
	B			0.12	$1,205		-4.24	-$36,770		-9.24	-$152,409
210039	A	Calvert	6,995	1	2.1	6,700	2	3.1	7,114	2	9.6
	B			-1.09	-$10,949		-1.12	-$9,713		-7.63	-$125,853
210040	A	Northwest	11,520	6	5.8	10,985	4	6.5	11,725	25	27.8
	B			0.16	$1,607		-2.45	-$21,247		-2.82	-$46,515
210043	A	Baltimore Washington	16,266	12	7.9	15,450	9	10.2	16,641	37	37.1
	B			4.06	$40,783		-1.18	-$10,233		-0.08	-$1,320
210044	A	GBMC	18,617	8	7.0	17,932	11	12.6	18,927	40	34.6
	B			0.97	$9,744		-1.57	-$13,615		5.44	$89,730
210045	A	McCready	657	0	0.2	618	0	0.3	667	0	1.0
	B			-0.21	-$2,109		-0.31	-$2,688		-1.04	-$17,154
210048	A	Howard	11,613	5	5.3	11,186	8	6.9	11,803	32	23.1
	B			-0.34	-$3,415		1.11	$9,626		8.93	$147,296
210049	A	Upper Chesapeake	13,503	6	4.8	13,035	5	6.7	13,726	19	22.8
	B			1.23	$12,355		-1.66	-$14,396		-3.75	-$61,854
210051	A	Doctors	10,171	11	4.5	9,692	13	6.9	10,385	37	22.8
	B			6.46	$64,891		6.09	$52,813		14.22	$234,552
210054	A	Southern Maryland	15,581	1	6.3	15,044	4	7.0	15,782	5	26.6
	B			-5.25	-$52,737		-3.03	-$26,277		-21.58	-$355,952
210055	A	Laurel	5,997	1	2.3	5,750	3	2.8	6,095	11	11.5
	B			-1.27	-$12,757		0.24	$2,081		-0.53	-$8,742
210056	A	Good Samaritan	15,157	4	8.7	14,657	5	8.4	15,468	51	41.8
	B			-4.71	-$47,313		-3.36	-$29,138		9.22	$152,080
210058	A	Kernan	2,397	1	0.8	2,379	1	1.5	2,408	3	7.8
	B			0.23	$2,310		-0.48	-$4,163		-4.80	-$79,174
210061	A	Atlantic General	3,252	1	1.4	3,074	2	2.3	3,304	8	8.2
	B			-0.40	-$4,018		-0.33	-$2,862		-0.16	-$2,639
210904	A	Hopkins Oncology	815	1	0.6	802	1	1.5	821	1	1.7
	B			0.45	$4,520		-0.53	-$4,596		-0.70	-$11,546
		Total	519,186	254		502,355	292		527,831	1,054	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 22			PPC 23			PPC 24		
			$6,462			$4,692			$7,920		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	12,898	172	163.7	13,701	13	9.4	12,172	140	129.5
	B			8.26	$53,376		3.64	$17,077		10.50	$83,158
210002	A	University Hospital	24,151	512	319.3	22,859	46	22.5	20,956	354	242.6
	B			192.67	$1,245,034		23.52	$110,344		111.41	$882,341
210003	A	Prince Georges	11,146	322	101.1	11,655	4	5.4	10,546	39	74.6
	B			220.87	$1,427,262		-1.44	-$6,756		-35.55	-$281,548
210004	A	Holy Cross	21,852	279	194.0	22,967	18	13.5	21,484	147	163.0
	B			85.05	$549,593		4.51	$21,159		-15.98	-$126,558
210005	A	Frederick	14,382	91	156.4	15,208	5	10.1	13,850	111	144.2
	B			-65.40	-$422,615		-5.05	-$23,692		-33.19	-$262,857
210006	A	Harford	6,147	72	58.9	6,689	2	2.9	5,934	72	48.1
	B			13.14	$84,911		-0.89	-$4,175		23.91	$189,362
210007	A	St. Joseph	19,259	229	239.2	20,520	10	16.0	18,840	204	211.6
	B			-10.18	-$65,783		-5.97	-$28,008		-7.62	-$60,349
210008	A	Mercy	14,399	141	128.2	15,049	9	9.5	13,844	58	105.6
	B			12.79	$82,649		-0.47	-$2,205		-47.56	-$376,664
210009	A	Hopkins Hospital	30,875	395	422.5	28,006	20	29.8	25,497	326	303.1
	B			-27.51	-$177,770		-9.79	-$45,930		22.93	$181,600
210010	A	Dorchester	2,793	29	28.6	3,121	6	1.7	2,903	25	28.4
	B			0.43	$2,779		4.26	$19,986		-3.44	-$27,244
210011	A	St. Agnes	15,810	139	173.5	16,435	6	11.6	14,563	193	156.2
	B			-34.45	-$222,616		-5.55	-$26,038		36.78	$291,289
210012	A	Sinai	20,846	378	324.3	20,810	26	16.1	18,920	395	223.5
	B			53.74	$347,268		9.89	$46,399		171.46	$1,357,923
210013	A	Bon Secours	5,302	67	64.2	5,755	2	3.8	4,856	26	53.6
	B			2.79	$18,029		-1.75	-$8,210		-27.61	-$218,665
210015	A	Franklin Square	22,343	136	224.8	23,257	6	14.7	21,497	171	218.0
	B			-88.83	-$574,020		-8.65	-$40,582		-46.97	-$371,991
210017	A	Garrett	2,314	19	24.3	2,348	3	1.6	2,118	18	19.0
	B			-5.33	-$34,442		1.42	$6,662		-0.95	-$7,524
210019	A	Peninsula Regional	16,769	142	236.9	17,778	4	15.5	15,745	205	230.2
	B			-94.87	-$613,050		-11.50	-$53,952		-25.22	-$199,736
210023	A	Anne Arundel	18,914	125	193.8	19,947	13	13.8	18,600	143	172.3
	B			-68.77	-$444,392		-0.75	-$3,519		-29.34	-$232,366
210024	A	Union Memorial	17,457	318	279.4	18,232	18	14.4	16,617	226	228.6
	B			38.57	$249,239		3.58	$16,796		-2.64	-$20,908
210025	A	Cumberland	6,412	72	81.8	6,630	5	3.9	6,162	31	53.1
	B			-9.75	-$63,005		1.07	$5,020		-22.07	-$174,789
210027	A	Sacred Heart	7,398	32	83.0	8,048	6	4.7	7,487	27	83.9
	B			-50.95	-$329,239		1.29	$6,052		-56.86	-$450,318
210028	A	St. Mary's	8,061	65	66.0	8,444	6	3.6	7,944	43	58.8
	B			-1.00	-$6,462		2.37	$11,119		-15.82	-$125,291
210029	A	Hopkins Bayview	16,607	188	176.6	17,804	10	11.2	15,853	214	156.5
	B			11.42	$73,796		-1.19	-$5,583		57.54	$455,703
210030	A	Chester River	2,848	25	27.3	3,040	5	2.0	2,826	19	28.8
	B			-2.34	-$15,121		3.00	$14,075		-9.84	-$77,930
210032	A	Union of Cecil 0907	6,823	54	66.8	7,342	4	4.5	6,689	59	64.2
	B			-12.76	-$82,455		-0.52	-$2,440		-5.20	-$41,183
210033	A	Carroll	12,707	73	125.4	13,762	4	8.3	13,324	61	134.4
	B			-52.36	-$338,350		-4.30	-$20,173		-73.39	-$581,231
210034	A	Harbor	11,067	59	111.5	11,605	6	7.4	10,268	144	100.2
	B			-52.54	-$339,514		-1.40	-$6,568		43.83	$347,123
210035	A	Civista_0807	6,136	115	58.8	6,589	3	3.9	6,034	18	51.3
	B			56.17	$362,971		-0.94	-$4,410		-33.28	-$263,570
210037	A	Easton	7,670	74	97.8	8,065	5	5.4	7,439	60	72.4
	B			-23.83	-$153,989		-0.36	-$1,689		-12.37	-$97,967
210038	A	Maryland General	8,738	59	125.1	9,509	5	6.7	7,744	110	81.4
	B			-66.12	-$427,268		-1.66	-$7,788		28.56	$226,188
210039	A	Calvert	6,569	59	56.0	6,894	7	3.5	6,520	57	51.6
	B			2.96	$19,128		3.51	$16,467		5.40	$42,767
210040	A	Northwest	10,168	88	125.8	11,504	6	8.6	9,658	142	114.6
	B			-37.77	-$244,070		-2.58	-$12,104		27.45	$217,398
210043	A	Baltimore Washington	14,737	132	175.0	16,096	9	11.7	15,123	92	193.1
	B			-42.96	-$277,608		-2.71	-$12,714		-101.05	-$800,292
210044	A	GBMC	17,579	149	165.1	18,462	8	12.5	17,259	145	150.5
	B			-16.14	-$104,297		-4.50	-$21,112		-5.46	-$43,242
210045	A	McCready	580	3	5.7	652	0	0.4	618	1	6.6
	B			-2.66	-$17,189		-0.35	-$1,642		-5.57	-$44,113
210048	A	Howard	10,929	93	107.9	11,556	6	7.5	10,770	92	99.4
	B			-14.91	-$96,348		-1.50	-$7,037		-7.42	-$58,765
210049	A	Upper Chesapeake	13,091	126	126.0	13,398	9	7.9	12,076	139	104.7
	B			-0.03	-$194		1.09	$5,114		34.34	$271,965
210051	A	Doctors	9,265	210	115.1	10,137	27	8.1	9,025	185	106.2
	B			94.86	$612,985		18.90	$88,670		78.78	$623,919
210054	A	Southern Maryland	14,918	69	147.3	15,579	5	8.4	13,615	96	118.5
	B			-78.30	-$505,975		-3.44	-$16,139		-22.52	-$178,353
210055	A	Laurel	5,417	200	77.5	5,981	6	3.8	5,327	31	51.0
	B			122.46	$791,337		2.25	$10,556		-19.97	-$158,158
210056	A	Good Samaritan	12,925	220	233.0	15,106	7	13.3	12,470	200	165.2
	B			-13.03	-$84,200		-6.30	-$29,557		34.78	$275,449
210058	A	Kernan	2,037	78	95.0	2,391	0	2.3	2,325	31	37.5
	B			-16.95	-$109,531		-2.31	-$10,837		-6.51	-$51,558
210061	A	Atlantic General	2,948	16	40.5	3,259	4	2.6	2,856	28	37.0
	B			-24.50	-$158,319		1.39	$6,521		-9.04	-$71,595
210904	A	Hopkins Oncology	981	8	10.0	807	1	0.8	794	4	9.3
	B			-1.95	-$12,601		0.18	$844		-5.26	-$41,658
		Total	494,268	5,833		516,997	365		468,948	4,882	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 25			PPC 27			PPC 28		
			$41,186			$4,256			$4,816		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	12,474	3	3.6	10,182	25	27.5	13,996	6	7.2
	B			-0.59	-$24,300		-2.45	-$10,426		-1.23	-$5,924
210002	A	University Hospital	21,186	13	10.1	19,573	69	48.3	23,248	18	22.7
	B			2.92	$120,264		20.71	$88,132		-4.70	-$22,638
210003	A	Prince Georges	10,698	1	2.2	8,617	10	9.1	11,762	78	12.2
	B			-1.21	-$49,836		0.86	$3,660		65.80	$316,926
210004	A	Holy Cross	21,821	5	5.0	12,634	38	32.2	23,270	4	7.8
	B			0.00	$0		5.78	$24,597		-3.83	-$18,447
210005	A	Frederick	14,064	3	4.6	11,468	20	28.5	15,596	12	6.7
	B			-1.64	-$67,546		-8.47	-$36,044		5.32	$25,624
210006	A	Harford	6,127	0	1.1	6,301	7	7.0	6,835	1	2.1
	B			-1.11	-$45,717		0.04	$170		-1.11	-$5,346
210007	A	St. Joseph	19,631	8	6.8	16,774	41	54.7	20,979	6	8.0
	B			1.23	$50,659		-13.71	-$58,344		-2.03	-$9,777
210008	A	Mercy	14,105	1	3.0	11,235	54	28.6	15,401	6	5.8
	B			-1.99	-$81,961		25.36	$107,921		0.21	$1,011
210009	A	Hopkins Hospital	26,023	15	11.3	23,571	39	44.3	28,602	4	16.3
	B			3.73	$153,625		-5.27	-$22,427		-12.28	-$59,147
210010	A	Dorchester	2,949	3	0.8	2,873	3	2.0	3,184	1	1.0
	B			2.17	$89,374		0.98	$4,170		0.03	$144
210011	A	St. Agnes	14,850	6	5.0	12,855	32	32.7	16,716	4	8.2
	B			0.98	$40,363		-0.66	-$2,809		-4.20	-$20,229
210012	A	Sinai	19,231	6	6.8	15,996	62	52.5	21,170	9	18.4
	B			-0.76	-$31,302		9.46	$40,257		-9.37	-$45,131
210013	A	Bon Secours	4,725	1	2.0	5,184	1	5.6	5,868	2	2.2
	B			-0.95	-$39,127		-4.59	-$19,533		-0.17	-$819
210015	A	Franklin Square	21,884	6	6.6	19,002	19	32.8	23,749	6	9.3
	B			-0.63	-$25,947		-13.83	-$58,854		-3.30	-$15,894
210017	A	Garrett	2,266	0	0.6	1,884	4	6.8	2,398	1	1.6
	B			-0.56	-$23,064		-2.77	-$11,788		-0.59	-$2,842
210019	A	Peninsula Regional	16,131	8	8.0	13,811	35	41.3	18,090	8	8.9
	B			-0.01	-$412		-6.33	-$26,938		-0.94	-$4,528
210023	A	Anne Arundel	18,830	9	4.9	13,197	25	54.2	20,291	4	9.4
	B			4.07	$167,629		-29.16	-$124,092		-5.44	-$26,202
210024	A	Union Memorial	16,899	7	8.1	17,039	13	70.5	18,475	6	12.5
	B			-1.11	-$45,717		-57.50	-$244,694		-6.49	-$31,259
210025	A	Cumberland	6,367	4	1.2	5,174	26	17.3	6,723	7	5.2
	B			2.77	$114,086		8.75	$37,236		1.77	$8,525
210027	A	Sacred Heart	7,814	1	2.9	7,430	3	6.7	8,263	1	2.5
	B			-1.87	-$77,019		-3.72	-$15,831		-1.51	-$7,273
210028	A	St. Mary's	8,056	0	1.3	6,837	0	9.5	8,650	0	2.6
	B			-1.34	-$55,190		-9.45	-$40,215		-2.57	-$12,378
210029	A	Hopkins Bayview	16,121	4	4.9	14,707	29	30.3	18,222	4	9.3
	B			-0.90	-$37,068		-1.30	-$5,532		-5.31	-$25,576
210030	A	Chester River	2,977	0	0.8	2,598	7	5.0	3,115	1	1.6
	B			-0.79	-$32,537		1.97	$8,383		-0.63	-$3,034
210032	A	Union of Cecil 0907	6,846	4	1.9	6,195	10	8.6	7,535	4	2.7
	B			2.11	$86,903		1.39	$5,915		1.26	$6,069
210033	A	Carroll	13,481	2	3.8	11,555	25	20.4	14,241	5	5.7
	B			-1.79	-$73,724		4.62	$19,661		-0.69	-$3,323
210034	A	Harbor	10,391	1	2.9	9,110	25	19.2	11,885	1	5.0
	B			-1.88	-$77,430		5.82	$24,767		-4.00	-$19,266
210035	A	Civista 0807	6,176	1	1.6	5,394	5	8.4	6,782	7	2.8
	B			-0.56	-$23,064		-3.38	-$14,384		4.24	$20,422
210037	A	Easton	7,575	2	1.9	6,326	30	16.7	8,231	4	3.7
	B			0.12	$4,942		13.32	$56,684		0.35	$1,686
210038	A	Maryland General	7,830	2	2.7	7,585	9	10.4	9,688	0	3.9
	B			-0.70	-$28,830		-1.42	-$6,043		-3.87	-$18,640
210039	A	Calvert	6,586	1	1.1	5,488	7	8.3	7,114	2	2.2
	B			-0.13	-$5,354		-1.27	-$5,405		-0.18	-$867
210040	A	Northwest	9,778	5	3.3	9,842	16	14.2	11,725	1	5.6
	B			1.68	$69,193		1.79	$7,617		-4.62	-$22,252
210043	A	Baltimore Washington	15,424	7	5.8	14,602	36	30.3	16,641	11	7.6
	B			1.19	$49,012		5.68	$24,172		3.44	$16,569
210044	A	GBMC	17,628	4	4.3	12,065	69	35.0	18,927	6	7.4
	B			-0.32	-$13,180		34.00	$144,689		-1.37	-$6,599
210045	A	McCready	623	0	0.1	580	1	0.3	667	1	0.2
	B			-0.14	-$5,766		0.69	$2,936		0.83	$3,998
210048	A	Howard	10,901	2	3.5	7,487	32	12.3	11,803	5	4.1
	B			-1.45	-$59,720		19.66	$83,664		0.89	$4,287
210049	A	Upper Chesapeake	12,480	6	2.8	11,112	32	19.4	13,726	9	5.2
	B			3.22	$132,620		12.64	$53,790		3.85	$18,544
210051	A	Doctors	9,128	2	2.9	8,901	14	14.9	10,385	3	4.9
	B			-0.94	-$38,715		-0.85	-$3,617		-1.92	-$9,248
210054	A	Southern Maryland	13,872	1	3.5	12,656	20	17.3	15,782	1	5.7
	B			-2.47	-$101,730		2.75	$11,703		-4.74	-$22,830
210055	A	Laurel	5,406	0	1.6	4,753	6	5.5	6,095	8	2.3
	B			-1.61	-$66,310		0.54	$2,298		5.73	$27,599
210056	A	Good Samaritan	12,855	6	4.6	13,670	22	44.6	15,468	5	10.3
	B			1.39	$57,249		-22.55	-$95,963		-5.25	-$25,287
210058	A	Kernan	2,348	0	0.7	1,555	12	9.9	2,408	2	3.1
	B			-0.71	-$29,242		2.15	$9,149		-1.10	-$5,298
210061	A	Atlantic General	2,886	1	1.2	2,750	19	8.9	3,304	2	1.8
	B			-0.17	-$7,002		10.14	$43,151		0.18	$867
210904	A	Hopkins Oncology	802	1	0.2	745	1	1.4	821	0	0.4
	B			0.76	$31,302		-0.44	-$1,872		-0.44	-$2,119
		Total	478,245	152		411,313	953		527,831	266	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 29			PPC 31			PPC 32		
			$1,415			$18,231			$48,575		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	13,615	6	6.2	13,681	39	21.6	13,996	0	0.0
	B			-0.15	-$212		17.36	$316,492		0.00	$0
210002	A	University Hospital	22,678	6	9.2	25,140	45	41.2	23,248	0	0.0
	B			-3.22	-$4,555		3.80	$69,278		0.00	$0
210003	A	Prince Georges	11,556	18	4.1	11,693	72	12.6	11,762	0	0.0
	B			13.95	$19,734		59.44	$1,083,655		0.00	$0
210004	A	Holy Cross	22,964	2	5.4	23,466	19	28.2	23,270	0	0.0
	B			-3.37	-$4,767		-9.24	-$168,455		0.00	$0
210005	A	Frederick	15,095	3	6.7	15,448	20	21.4	15,596	0	0.0
	B			-3.67	-$5,192		-1.35	-$24,612		0.00	$0
210006	A	Harford	6,642	3	4.8	6,658	7	7.1	6,835	0	0.0
	B			-1.84	-$2,603		-0.13	-$2,370		0.00	$0
210007	A	St. Joseph	20,727	1	7.3	20,748	19	34.4	20,979	0	0.0
	B			-6.33	-$8,955		-15.42	-$281,123		0.00	$0
210008	A	Mercy	15,051	7	4.9	15,208	6	13.6	15,401	0	0.0
	B			2.10	$2,971		-7.57	-$138,009		0.00	$0
210009	A	Hopkins Hospital	27,729	8	12.3	32,900	47	57.7	28,602	0	0.0
	B			-4.29	-$6,069		-10.74	-$195,802		0.00	$0
210010	A	Dorchester	3,035	4	1.9	3,097	4	3.2	3,184	0	0.0
	B			2.07	$2,928		0.77	$14,038		0.00	$0
210011	A	St. Agnes	16,333	23	5.7	16,877	14	23.9	16,716	0	0.0
	B			17.27	$24,431		-9.93	-$181,035		0.00	$0
210012	A	Sinai	20,668	12	8.7	21,962	25	48.1	21,170	0	0.0
	B			3.28	$4,640		-23.11	-$421,320		0.00	$0
210013	A	Bon Secours	5,742	3	3.9	5,574	7	10.0	5,868	0	0.0
	B			-0.94	-$1,330		-3.00	-$54,693		0.00	$0
210015	A	Franklin Square	23,232	4	8.3	23,889	18	29.6	23,749	0	0.0
	B			-4.31	-$6,097		-11.57	-$210,934		0.00	$0
210017	A	Garrett	2,344	0	0.9	2,409	1	3.2	2,398	0	0.0
	B			-0.89	-$1,259		-2.20	-$40,108		0.00	$0
210019	A	Peninsula Regional	17,708	3	6.7	17,366	112	38.8	18,090	0	0.0
	B			-3.66	-$5,178		73.20	$1,334,515		0.00	$0
210023	A	Anne Arundel	19,975	14	6.3	20,272	11	27.4	20,291	0	0.0
	B			7.71	$10,907		-16.35	-$298,078		0.00	$0
210024	A	Union Memorial	18,184	4	8.8	17,982	72	41.5	18,475	0	0.0
	B			-4.81	-$6,804		30.50	$556,048		0.00	$0
210025	A	Cumberland	6,645	4	2.4	6,858	9	9.2	6,723	0	0.0
	B			1.63	$2,306		-0.17	-$3,099		0.00	$0
210027	A	Sacred Heart	7,952	3	3.7	8,022	2	11.9	8,263	0	0.0
	B			-0.66	-$934		-9.92	-$180,852		0.00	$0
210028	A	St. Mary's	8,437	1	3.0	8,678	3	7.1	8,650	0	0.0
	B			-2.00	-$2,829		-4.07	-$74,200		0.00	$0
210029	A	Hopkins Bayview	17,776	2	7.5	17,643	13	22.5	18,222	0	0.0
	B			-5.53	-$7,823		-9.54	-$173,924		0.00	$0
210030	A	Chester River	3,048	0	0.9	3,131	3	3.4	3,115	0	0.0
	B			-0.91	-$1,287		-0.40	-$7,292		0.00	$0
210032	A	Union of Cecil 0907	7,322	4	2.8	7,568	7	8.7	7,535	0	0.0
	B			1.17	$1,655		-1.73	-$31,540		0.00	$0
210033	A	Carroll	13,872	3	6.3	14,317	3	16.6	14,241	0	0.0
	B			-3.27	-$4,626		-13.62	-$248,307		0.00	$0
210034	A	Harbor	11,646	1	4.6	11,833	14	14.0	11,885	0	0.0
	B			-3.64	-$5,149		0.05	$912		0.00	$0
210035	A	Civista 0807	6,616	4	1.9	6,755	10	8.1	6,782	0	0.0
	B			2.14	$3,027		1.93	$35,186		0.00	$0
210037	A	Easton	8,108	2	2.7	8,369	11	11.6	8,231	0	0.0
	B			-0.68	-$962		-0.64	-$11,668		0.00	$0
210038	A	Maryland General	9,496	0	6.1	9,091	5	17.1	9,688	0	0.0
	B			-6.08	-$8,601		-12.10	-$220,596		0.00	$0
210039	A	Calvert	6,978	0	3.9	7,248	5	6.3	7,114	0	0.0
	B			-3.86	-$5,460		-1.31	-$23,883		0.00	$0
210040	A	Northwest	11,467	2	5.6	11,024	3	18.4	11,725	0	0.0
	B			-3.63	-$5,135		-15.43	-$281,306		0.00	$0
210043	A	Baltimore Washington	16,087	3	6.7	16,309	18	23.0	16,641	0	0.0
	B			-3.69	-$5,220		-5.04	-$91,885		0.00	$0
210044	A	GBMC	18,589	9	5.2	18,586	19	20.1	18,927	0	0.0
	B			3.81	$5,390		-1.05	-$19,143		0.00	$0
210045	A	McCready	657	0	0.2	638	0	0.6	667	0	0.0
	B			-0.19	-$269		-0.62	-$11,303		0.00	$0
210048	A	Howard	11,604	2	4.5	11,966	7	16.1	11,803	0	0.0
	B			-2.49	-$3,522		-9.06	-$165,174		0.00	$0
210049	A	Upper Chesapeake	13,440	3	4.0	14,121	9	16.7	13,726	0	0.0
	B			-0.95	-$1,344		-7.70	-$140,379		0.00	$0
210051	A	Doctors	10,150	13	3.6	9,878	23	15.7	10,385	0	0.0
	B			9.40	$13,298		7.27	$132,540		0.00	$0
210054	A	Southern Maryland	15,521	4	6.3	15,544	3	16.7	15,782	0	0.0
	B			-2.26	-$3,197		-13.66	-$249,037		0.00	$0
210055	A	Laurel	5,889	20	3.2	5,882	44	11.8	6,095	0	0.0
	B			16.78	$23,738		32.23	$587,588		0.00	$0
210056	A	Good Samaritan	15,125	5	7.5	14,014	8	32.8	15,468	0	0.0
	B			-2.52	-$3,565		-24.76	-$451,401		0.00	$0
210058	A	Kernan	2,371	1	1.1	2,174	28	14.1	2,408	0	0.0
	B			-0.09	-$127		13.93	$253,959		0.00	$0
210061	A	Atlantic General	3,213	0	1.3	3,137	6	5.1	3,304	0	0.0
	B			-1.27	-$1,797		0.89	$16,226		0.00	$0
210904	A	Hopkins Oncology	809	0	0.1	1,012	2	1.9	821	0	0.0
	B			-0.13	-$184		0.06	$1,094		0.00	$0
		Total	516,096	207		528,168	793		527,831	0	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 33			PPC 34			PPC 35		
			$2,864			$12,922			$14,088		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	12,220	35	25.9	10,809	11	10.9	13,511	59	89.6
	B			9.10	$26,064		0.11	$1,421		-30.64	-$431,668
210002	A	University Hospital	19,881	67	48.6	18,877	77	33.9	22,645	205	184.6
	B			18.38	$52,644		43.10	$556,931		20.44	$287,966
210003	A	Prince Georges	10,531	42	15.4	10,070	30	8.0	11,177	177	43.6
	B			26.61	$76,217		21.96	$283,764		133.42	$1,879,670
210004	A	Holy Cross	20,357	18	26.4	19,156	23	17.1	21,516	188	88.0
	B			-8.35	-$23,916		5.86	$75,722		100.03	$1,409,259
210005	A	Frederick	13,731	23	21.6	12,374	4	12.2	14,922	64	93.5
	B			1.39	$3,981		-8.17	-$105,571		-29.49	-$415,466
210006	A	Harford	5,967	9	8.4	5,602	2	4.2	6,497	64	27.4
	B			0.63	$1,804		-2.24	-$28,945		36.64	$516,198
210007	A	St. Joseph	18,698	29	42.5	17,793	15	17.2	20,322	96	119.0
	B			-13.47	-$38,581		-2.24	-$28,945		-23.01	-$324,173
210008	A	Mercy	13,639	19	23.0	12,891	7	11.9	15,079	14	72.6
	B			-3.99	-$11,428		-4.91	-$63,446		-58.56	-$825,015
210009	A	Hopkins Hospital	24,224	71	61.3	22,966	50	42.9	27,464	173	224.0
	B			9.72	$27,840		7.15	$92,391		-51.04	-$719,070
210010	A	Dorchester	2,696	1	4.2	2,483	2	2.0	3,103	8	16.2
	B			-3.16	-$9,051		-0.02	-$258		-8.23	-$115,947
210011	A	St. Agnes	14,338	24	26.5	12,974	19	14.3	16,111	101	116.7
	B			-2.46	-$7,046		4.67	$60,345		-15.71	-$221,328
210012	A	Sinai	18,323	65	51.7	17,415	10	22.4	20,225	155	133.8
	B			13.31	$38,123		-12.38	-$159,972		21.20	$298,673
210013	A	Bon Secours	4,700	19	8.8	4,185	1	5.3	5,402	38	37.9
	B			10.18	$29,158		-4.31	-$55,693		0.11	$1,550
210015	A	Franklin Square	20,441	29	33.4	18,922	6	18.2	22,593	124	125.0
	B			-4.40	-$12,603		-12.24	-$158,163		-1.02	-$14,370
210017	A	Garrett	2,134	0	3.9	1,931	1	1.8	2,311	5	12.6
	B			-3.92	-$11,228		-0.76	-$9,821		-7.61	-$107,212
210019	A	Peninsula Regional	15,570	22	36.7	14,135	4	16.5	17,019	155	134.7
	B			-14.65	-$41,961		-12.46	-$161,006		20.34	$286,557
210023	A	Anne Arundel	17,381	23	28.0	16,343	7	14.6	19,079	65	98.1
	B			-4.96	-$14,207		-7.60	-$98,206		-33.11	-$466,466
210024	A	Union Memorial	16,182	38	53.0	15,387	14	16.1	18,057	85	111.1
	B			-15.01	-$42,992		-2.09	-$27,007		-26.13	-$368,129
210025	A	Cumberland	5,841	7	13.4	5,477	10	5.1	6,579	15	28.0
	B			-6.36	-$18,216		4.94	$63,834		-13.03	-$183,571
210027	A	Sacred Heart	7,203	11	13.9	6,719	3	5.0	7,963	27	42.5
	B			-2.94	-$8,421		-2.03	-$26,231		-15.52	-$218,651
210028	A	St. Mary's	7,879	6	10.8	7,185	0	5.0	8,451	12	33.7
	B			-4.81	-$13,777		-4.99	-$64,480		-21.72	-$305,999
210029	A	Hopkins Bayview	15,375	19	24.6	14,181	26	15.6	17,736	70	115.7
	B			-5.59	-$16,011		10.44	$134,904		-45.71	-$643,979
210030	A	Chester River	2,615	3	4.4	2,343	1	2.0	2,991	11	15.4
	B			-1.36	-$3,895		-0.99	-$12,793		-4.35	-$61,284
210032	A	Union of Cecil 0907	6,333	9	10.3	5,658	5	5.5	7,299	32	43.0
	B			-1.29	-$3,695		-0.49	-$6,332		-10.95	-$154,268
210033	A	Carroll	12,314	14	19.7	11,217	4	10.0	13,845	60	77.2
	B			-5.71	-$16,355		-5.99	-$77,402		-17.23	-$242,743
210034	A	Harbor	9,875	8	14.9	9,013	1	8.3	11,455	45	70.4
	B			-6.89	-$19,734		-7.27	-$93,942		-25.41	-$357,985
210035	A	Civista 0807	5,797	30	9.6	5,215	8	4.9	6,532	50	34.6
	B			20.39	$58,401		3.09	$39,928		15.42	$217,243
210037	A	Easton	7,155	11	17.3	6,583	5	6.4	8,051	23	42.7
	B			-6.31	-$18,073		-1.40	-$18,091		-19.67	-$277,118
210038	A	Maryland General	7,837	7	19.2	7,207	11	7.8	9,060	73	61.3
	B			-12.16	-$34,829		3.23	$41,738		11.72	$165,116
210039	A	Calvert	6,265	15	8.6	5,786	5	4.5	6,958	8	30.5
	B			6.37	$18,245		0.51	$6,590		-22.45	-$316,284
210040	A	Northwest	9,780	13	18.0	8,819	6	9.3	11,042	53	79.2
	B			-4.98	-$14,264		-3.28	-$42,384		-26.18	-$368,833
210043	A	Baltimore Washington	13,994	34	27.7	12,415	7	12.7	15,929	101	113.4
	B			6.28	$17,987		-5.68	-$73,396		-12.38	-$174,414
210044	A	GBMC	16,475	28	27.7	15,358	9	15.5	18,349	79	111.2
	B			0.32	$917		-6.49	-$83,863		-32.24	-$454,209
210045	A	McCready	538	1	0.9	481	0	0.4	631	0	2.8
	B			0.11	$315		-0.42	-$5,427		-2.82	-$39,729
210048	A	Howard	10,172	21	16.0	9,193	7	8.5	11,102	115	64.7
	B			5.01	$14,350		-1.47	-$18,995		50.28	$708,363
210049	A	Upper Chesapeake	12,038	11	18.3	11,282	3	9.9	13,046	94	64.8
	B			-7.31	-$20,937		-6.92	-$89,419		29.24	$411,944
210051	A	Doctors	8,298	28	16.3	7,499	17	8.4	9,338	146	56.8
	B			11.68	$33,454		8.64	$111,645		89.18	$1,256,401
210054	A	Southern Maryland	13,986	4	21.6	12,903	12	11.3	15,246	69	83.1
	B			-17.61	-$50,439		0.74	$9,562		-14.05	-$197,942
210055	A	Laurel	5,131	37	13.3	4,662	14	4.5	5,590	130	27.1
	B			23.74	$67,997		9.54	$123,274		102.95	$1,450,397
210056	A	Good Samaritan	12,514	16	42.6	11,375	6	15.6	14,769	64	109.9
	B			-26.56	-$76,074		-9.55	-$123,404		-45.90	-$646,656
210058	A	Kernan	2,039	47	23.9	1,930	3	4.4	2,358	5	16.5
	B			23.07	$66,077		-1.39	-$17,961		-11.47	-$161,594
210061	A	Atlantic General	2,846	4	6.2	2,484	7	2.7	3,160	20	24.9
	B			-2.24	-$6,416		4.26	$55,047		-4.92	-$69,315
210904	A	Hopkins Oncology	754	4	3.8	724	1	1.5	798	8	8.4
	B			0.20	$573		-0.45	-$5,815		-0.43	-$6,058
		Total	454,067	922		420,022	454		505,311	3,086	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 36			PPC 37			PPC 38		
				$3,631			$15,778			$30,875	
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	10,809	25	21.6	3,167	9	16.1	3,167	2	1.5
	B			3.39	$12,308		-7.05	-$111,233		0.50	$15,437
210002	A	University Hospital	17,041	11	36.4	8,199	71	62.9	8,197	6	2.5
	B			-25.37	-$92,113		8.15	$128,588		3.46	$106,827
210003	A	Prince Georges	8,435	1	9.5	2,797	3	6.3	2,797	2	0.4
	B			-8.49	-$30,825		-3.31	-$52,224		1.56	$48,165
210004	A	Holy Cross	20,864	12	24.8	7,304	26	21.8	7,304	1	2.7
	B			-12.76	-$46,329		4.22	$66,582		-1.65	-$50,943
210005	A	Frederick	11,943	16	21.1	3,397	18	15.9	3,397	2	1.2
	B			-5.12	-$18,590		2.06	$32,502		0.79	$24,391
210006	A	Harford	4,258	8	6.7	595	5	4.8	595	0	0.5
	B			1.28	$4,647		0.19	$2,998		-0.45	-$13,894
210007	A	St. Joseph	18,073	27	36.7	10,301	39	45.4	10,301	0	2.5
	B			-9.69	-$35,182		-6.40	-$100,977		-2.48	-$76,569
210008	A	Mercy	11,759	6	18.9	5,243	17	23.0	5,243	3	1.4
	B			-12.88	-$46,765		-5.97	-$94,193		1.59	$49,091
210009	A	Hopkins Hospital	21,794	53	46.8	12,972	141	84.1	12,965	4	3.0
	B			6.24	$22,656		56.89	$897,595		0.97	$29,948
210010	A	Dorchester	1,879	12	3.2	277	1	2.1	277	0	0.2
	B			8.78	$31,878		-1.08	-$17,040		-0.18	-$5,557
210011	A	St. Agnes	13,266	28	22.8	5,313	29	23.2	5,310	2	2.6
	B			5.18	$18,808		5.85	$92,300		-0.60	-$18,525
210012	A	Sinai	16,066	39	34.5	7,654	24	34.3	7,654	3	2.2
	B			4.47	$16,230		-10.26	-$161,879		0.83	$25,626
210013	A	Bon Secours	2,380	0	5.0	442	3	4.0	442	0	0.3
	B			-4.96	-$18,009		-1.02	-$16,093		-0.33	-$10,189
210015	A	Franklin Square	18,088	46	29.0	5,251	22	26.1	5,251	1	1.8
	B			17.02	$61,796		-4.07	-$64,215		-0.84	-$25,935
210017	A	Garrett	2,034	4	3.9	675	3	3.8	675	0	0.3
	B			0.09	$327		-0.77	-$12,149		-0.34	-$10,497
210019	A	Pennisula Regional	14,795	16	31.1	6,983	15	35.5	6,982	1	1.8
	B			-15.12	-$54,898		-20.46	-$322,812		-0.80	-$24,700
210023	A	Anne Arundel	17,852	27	31.2	7,379	31	28.6	7,379	2	1.9
	B			-4.24	-$15,395		2.38	$37,551		0.11	$3,396
210024	A	Union Memorial	13,635	44	35.8	8,757	28	36.8	8,757	1	1.0
	B			8.22	$29,845		-8.81	-$139,002		0.00	$0
210025	A	Cumberland	5,395	21	10.9	1,719	5	4.8	1,719	1	0.3
	B			10.15	$36,853		0.23	$3,629		0.72	$22,230
210027	A	Sacred Heart	5,808	12	9.7	1,770	12	9.1	1,770	0	0.4
	B			2.32	$8,423		2.89	$45,598		-0.35	-$10,806
210028	A	St. Mary's	7,017	0	8.5	1,141	2	5.4	1,141	1	0.5
	B			-8.53	-$30,971		-3.39	-$53,486		0.54	$16,672
210029	A	Hopkins Bayview	11,417	18	21.7	3,899	28	17.4	3,899	3	1.2
	B			-3.66	-$13,289		10.63	$167,717		1.82	$56,192
210030	A	Chester River	2,539	3	4.1	599	1	3.8	599	0	0.3
	B			-1.14	-$4,139		-2.84	-$44,809		-0.31	-$9,571
210032	A	Union of Cecil 0907	5,394	18	8.8	1,073	5	7.9	1,073	1	0.8
	B			9.22	$33,476		-2.87	-$45,282		0.16	$4,940
210033	A	Carroll	10,425	7	17.2	2,988	20	14.1	2,988	0	1.2
	B			-10.19	-$36,998		5.91	$93,246		-1.23	-$37,976
210034	A	Harbor	9,172	11	15.6	2,803	10	11.4	2,803	1	0.9
	B			-4.56	-$16,556		-1.36	-$21,458		0.07	$2,161
210035	A	Civista 0807	5,659	9	7.7	1,359	6	5.8	1,359	0	0.4
	B			1.31	$4,756		0.16	$2,524		-0.44	-$13,585
210037	A	Easton	6,716	20	12.6	1,932	9	9.2	1,932	0	0.7
	B			7.37	$26,759		-0.17	-$2,682		-0.68	-$20,995
210038	A	Maryland General	5,015	4	9.6	1,152	4	6.1	1,152	0	0.6
	B			-5.60	-$20,332		-2.14	-$33,764		-0.60	-$18,525
210039	A	Calvert	5,534	4	7.3	1,313	3	4.9	1,313	0	0.4
	B			-3.25	-$11,800		-1.87	-$29,504		-0.44	-$13,585
210040	A	Northwest	8,079	19	15.6	1,383	11	12.7	1,383	0	0.8
	B			3.38	$12,272		-1.68	-$26,507		-0.84	-$25,935
210043	A	Baltimore Washington	12,413	27	25.9	3,723	22	23.9	3,723	5	1.6
	B			1.07	$3,885		-1.85	-$29,189		3.38	$104,357
210044	A	GBMC	16,206	63	25.6	7,307	34	32.4	7,307	1	3.1
	B			37.39	$135,755		1.60	$25,244		-2.08	-$64,219
210045	A	McCready	492	1	0.7	35	0	0.4	35	0	0.0
	B			0.33	$1,198		-0.44	-$6,942		-0.02	-$617
210048	A	Howard	9,441	22	14.3	3,222	23	15.2	3,222	2	1.4
	B			7.70	$27,957		7.76	$122,435		0.58	$17,290
210049	A	Upper Chesapeake	11,262	21	16.7	2,837	10	12.6	2,837	0	0.7
	B			4.27	$15,504		-2.57	-$40,549		-0.73	-$22,539
210051	A	Doctors	8,580	15	14.2	1,757	17	11.9	1,757	0	1.0
	B			0.80	$2,905		5.11	$80,624		-0.98	-$30,257
210054	A	Southern Maryland	12,241	2	15.5	2,627	4	11.7	2,627	1	1.0
	B			-13.53	-$49,125		-7.69	-$121,331		0.01	$309
210055	A	Laurel	4,339	3	7.1	737	0	3.3	737	0	0.3
	B			-4.13	-$14,995		-3.32	-$52,382		-0.26	-$8,027
210056	A	Good Samaritan	11,761	31	29.5	3,261	5	15.1	3,261	0	0.7
	B			1.54	$5,591		-10.11	-$159,513		-0.69	-$21,304
210058	A	Kernan	2,099	4	8.1	536	1	1.4	536	0	0.0
	B			-4.14	-$15,031		-0.37	-$5,838		0.00	$0
210061	A	Atlantic General	2,604	16	6.3	682	2	5.1	682	0	0.4
	B			9.73	$35,328		-3.12	-$49,226		-0.36	-$11,115
210904	A	Hopkins Oncology	782	8	1.9	613	10	9.0	613	1	0.4
	B						0.97	$15,304		0.60	$18,525
		Total	405,361	6.08 734	$22,075	147,174	729		147,161	47	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 39			PPC 40			PPC 41		
			$13,777			$6,536			$11,158		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	3,054	0	2.4	4,117	52	55.6	3,275	3	4.2
	B			-2.40	-$33,064		-3.62	-$23,660		-1.24	-$13,836
210002	A	University Hospital	7,753	13	8.6	9,803	331	221.4	8,156	12	15.9
	B			4.41	$60,755		109.58	$716,219		-3.93	-$43,852
210003	A	Prince Georges	2,753	6	1.5	3,723	29	43.0	2,868	0	2.3
	B			4.52	$62,271		-14.00	-$91,504		-2.29	-$25,552
210004	A	Holy Cross	7,207	5	4.7	8,821	89	91.9	7,530	9	8.5
	B			0.29	$3,995		-2.86	-$18,693		0.54	$6,025
210005	A	Frederick	3,302	4	2.5	4,617	46	55.4	3,514	6	3.9
	B			1.46	$20,114		-9.43	-$61,635		2.13	$23,767
210006	A	Harford	590	1	0.7	1,158	10	11.2	630	0	0.8
	B			0.28	$3,857		-1.15	-$7,516		-0.76	-$8,480
210007	A	St. Joseph	10,229	2	7.4	11,954	220	245.0	10,467	16	15.9
	B			-5.43	-$74,807		-24.96	-$163,139		0.13	$1,451
210008	A	Mercy	5,050	5	4.4	6,330	89	98.1	5,288	1	8.3
	B			0.65	$8,955		-9.09	-$59,413		-7.26	-$81,008
210009	A	Hopkins Hospital	10,850	18	13.5	13,907	378	285.8	11,602	22	20.0
	B			4.55	$62,684		92.20	$602,622		1.99	$22,205
210010	A	Dorchester	270	0	0.2	583	18	6.1	290	0	0.6
	B			-0.21	-$2,893		11.93	$77,975		-0.58	-$6,472
210011	A	St. Agnes	5,114	4	5.7	7,112	155	96.6	5,419	12	7.4
	B			-1.72	-$23,696		58.39	$381,639		4.56	$50,881
210012	A	Sinai	7,206	6	6.1	9,078	206	147.6	7,494	15	10.0
	B			-0.06	-$827		58.40	$381,704		5.02	$56,014
210013	A	Bon Secours	450	1	0.6	1,408	15	15.0	533	0	1.0
	B			0.43	$5,924		-0.02	-$131		-0.99	-$11,047
210015	A	Franklin Square	5,080	5	6.0	6,870	80	102.0	5,423	8	8.6
	B			-1.02	-$14,052		-22.03	-$143,989		-0.64	-$7,141
210017	A	Garrett	655	0	0.4	824	16	9.5	669	2	0.7
	B			-0.37	-$5,097		6.52	$42,615		1.32	$14,729
210019	A	Peninsula Regional	6,907	2	6.4	8,467	60	164.9	7,174	6	12.0
	B			-4.39	-$60,480		-104.94	-$685,891		-5.99	-$66,838
210023	A	Anne Arundel	7,194	2	4.9	8,832	101	118.5	7,555	17	7.2
	B			-2.91	-$40,090		-17.50	-$114,381		9.85	$109,908
210024	A	Union Memorial	8,744	7	5.8	10,129	96	222.0	8,913	15	14.3
	B			1.16	$15,981		-125.98	-$823,410		0.68	$7,588
210025	A	Cumberland	1,678	0	0.6	2,185	37	24.4	1,729	2	1.1
	B			-0.58	-$7,990		12.56	$82,093		0.88	$9,819
210027	A	Sacred Heart	1,757	2	1.5	2,441	50	47.6	1,829	2	3.5
	B			0.55	$7,577		2.44	$15,948		-1.53	-$17,072
210028	A	St. Mary's	1,114	2	0.9	1,420	8	16.1	1,168	1	1.3
	B			1.15	$15,843		-8.13	-$53,138		-0.29	-$3,236
210029	A	Hopkins Bayview	3,727	3	3.3	5,188	66	71.8	4,009	2	4.7
	B			-0.28	-$3,857		-5.76	-$37,648		-2.65	-$29,569
210030	A	Chester River	590	0	0.5	915	8	10.1	613	0	0.7
	B			-0.53	-$7,302		-2.14	-$13,987		-0.73	-$8,145
210032	A	Union of Cecil 0907	1,060	0	1.2	1,648	11	18.5	1,141	4	1.9
	B			-1.17	-$16,119		-7.54	-$49,282		2.08	$23,209
210033	A	Carroll	2,848	1	2.5	4,095	21	48.5	3,051	1	4.2
	B			-1.45	-$19,976		-27.50	-$179,741		-3.21	-$35,818
210034	A	Harbor	2,721	3	1.9	4,010	40	47.5	2,876	5	3.6
	B			1.12	$15,430		-7.47	-$48,824		1.38	$15,398
210035	A	Civista 0807	1,333	0	0.9	1,921	21	20.5	1,409	0	1.7
	B			-0.93	-$12,812		0.53	$3,464		-1.69	-$18,857
210037	A	Easton	1,882	5	1.2	2,670	25	33.3	1,950	5	2.2
	B			3.77	$51,938		-8.32	-$54,380		2.80	$31,243
210038	A	Maryland General	1,121	0	1.3	2,376	12	24.7	1,257	0	1.7
	B			-1.32	-$18,185		-12.73	-$83,204		-1.67	-$18,634
210039	A	Calvert	1,290	1	0.6	1,948	32	18.4	1,341	1	1.5
	B			0.37	$5,097		13.60	$88,890		-0.47	-$5,244
210040	A	Northwest	1,364	0	1.7	2,888	10	34.3	1,489	0	2.6
	B			-1.72	-$23,696		-24.26	-$158,564		-2.55	-$28,453
210043	A	Baltimore Washington	3,530	7	3.6	5,677	48	83.0	3,890	9	6.2
	B			3.38	$46,565		-35.04	-$229,023		2.77	$30,908
210044	A	GBMC	7,126	1	6.1	8,629	130	102.5	7,456	8	9.3
	B			-5.11	-$70,399		27.51	$179,806		-1.26	-$14,059
210045	A	McCready	34	0	0.1	66	1	0.7	40	0	0.1
	B			-0.05	-$689		0.35	$2,288		-0.10	-$1,116
210048	A	Howard	3,082	4	2.7	4,219	46	43.4	3,326	7	3.6
	B			1.29	$17,772		2.61	$17,059		3.38	$37,715
210049	A	Upper Chesapeake	2,777	1	2.2	3,893	30	49.9	2,981	3	4.0
	B			-1.24	-$17,083		-19.94	-$130,329		-0.96	-$10,712
210051	A	Doctors	1,735	4	1.4	3,322	38	39.5	1,931	2	3.2
	B			2.59	$35,682		-1.48	-$9,673		-1.17	-$13,055
210054	A	Southern Maryland	2,603	3	2.7	4,233	19	51.2	2,738	4	3.8
	B			0.35	$4,822		-32.18	-$210,330		0.21	$2,343
210055	A	Laurel	738	1	0.5	1,240	5	11.6	806	0	0.8
	B			0.54	$7,439		-6.56	-$42,876		-0.83	-$9,261
210056	A	Good Samaritan	3,230	2	1.9	5,065	46	72.9	3,451	4	3.7
	B			0.11	$1,515		-26.93	-$176,015		0.26	$2,901
210058	A	Kernan	525	0	0.1	593	175	9.6	531	0	0.1
	B			-0.06	-$827		165.44	$1,081,321		-0.11	-$1,227
210061	A	Atlantic General	666	0	0.5	939	11	13.5	736	5	1.0
	B			-0.50	-$6,888		-2.45	-$16,013		4.00	$44,633
210904	A	Hopkins Oncology	572	1	0.5	633	15	13.1	580	0	1.1
	B			0.49	$6,751		1.94	$12,680		-1.07	-$11,939
		Total	141,511	122		189,947	2,896		149,128	209	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 42			PPC 44			PPC 45		
			$3,836			$12,509			$5,203		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	4,039	42	36.5	3,278	11	7.4	3,278	1	0.3
	B			5.52	$21,173		3.65	$45,657		0.70	$3,642
210002	A	University Hospital	9,623	145	102.0	8,183	36	26.0	8,183	0	1.6
	B			43.05	$165,126		9.99	$124,962		-1.59	-$8,273
210003	A	Prince Georges	3,595	4	17.1	2,869	3	4.1	2,869	0	0.2
	B			-13.12	-$50,324		-1.05	-$13,134		-0.17	-$885
210004	A	Holy Cross	8,717	47	73.8	7,533	7	10.3	7,533	1	0.8
	B			-26.76	-$102,643		-3.25	-$40,653		0.24	$1,249
210005	A	Frederick	4,578	22	33.3	3,519	7	6.9	3,519	1	0.4
	B			-11.27	-$43,228		0.08	$1,001		0.64	$3,330
210006	A	Harford	1,110	13	6.8	630	0	1.3	630	1	0.1
	B			6.16	$23,628		-1.26	-$15,761		0.93	$4,839
210007	A	St. Joseph	11,749	89	100.5	10,472	18	17.5	10,472	1	1.2
	B			-11.50	-$44,110		0.55	$6,880		-0.15	-$780
210008	A	Mercy	6,213	66	73.3	5,295	10	10.0	5,295	1	0.6
	B			-7.27	-$27,885		0.02	$250		0.44	$2,289
210009	A	Hopkins Hospital	13,745	193	157.6	11,651	42	33.5	11,651	1	2.8
	B			35.40	$135,783		8.47	$105,949		-1.76	-$9,158
210010	A	Dorchester	557	9	5.5	291	1	0.9	291	0	0.0
	B			3.48	$13,348		0.14	$1,751		-0.04	-$208
210011	A	St. Agnes	6,924	102	57.8	5,428	16	10.7	5,428	0	0.6
	B			44.22	$169,614		5.33	$86,672		-0.59	-$3,070
210012	A	Sinai	8,917	77	74.7	7,498	13	14.7	7,498	1	0.8
	B			2.32	$8,899		-1.71	-$21,390		0.20	$1,041
210013	A	Bon Secours	1,277	6	5.7	533	3	2.5	533	1	0.1
	B			0.31	$1,189		0.53	$6,630		0.93	$4,839
210015	A	Franklin Square	6,708	46	58.6	5,425	8	12.6	5,425	0	0.6
	B			-12.62	-$48,406		-4.57	-$57,165		-0.64	-$3,330
210017	A	Garrett	818	7	5.2	669	4	1.4	669	0	0.1
	B			1.79	$6,866		2.59	$32,398		-0.05	-$260
210019	A	Pennisula Regional	8,257	30	54.6	7,177	8	15.0	7,177	0	0.8
	B			-24.58	-$94,281		-6.95	-$86,936		-0.75	-$3,902
210023	A	Anne Arundel	8,743	78	82.0	7,566	13	12.9	7,566	2	0.8
	B			-4.00	-$15,343		0.12	$1,501		1.17	$6,088
210024	A	Union Memorial	9,881	54	56.1	8,916	5	15.4	8,916	1	1.0
	B			-2.11	-$8,093		-10.40	-$130,091		0.04	$208
210025	A	Cumberland	2,146	21	10.6	1,729	5	2.7	1,729	0	0.1
	B			10.39	$39,853		2.31	$28,895		-0.11	-$572
210027	A	Sacred Heart	2,373	14	13.4	1,829	1	3.9	1,829	0	0.3
	B			0.56	$2,148		-2.85	-$35,650		-0.26	-$1,353
210028	A	St. Mary's	1,378	6	9.6	1,168	1	2.4	1,168	1	0.1
	B			-3.64	-$13,962		-1.43	-$17,888		0.90	$4,683
210029	A	Hopkins Bayview	5,034	28	37.5	4,011	15	9.8	4,011	1	0.5
	B			-9.54	-$36,592		5.19	$64,920		0.53	$2,758
210030	A	Chester River	902	2	6.5	613	4	1.5	613	0	0.1
	B			-4.48	-$17,184		2.53	$31,647		-0.05	-$260
210032	A	Union of Cecil 0907	1,617	22	14.5	1,141	2	2.9	1,141	0	0.1
	B			7.51	$28,806		-0.94	-$11,758		-0.13	-$676
210033	A	Carroll	4,036	13	31.1	3,052	8	6.1	3,052	0	0.3
	B			-18.09	-$69,388		1.92	$24,017		-0.31	-$1,613
210034	A	Harbor	3,905	11	37.1	2,876	8	5.2	2,876	0	0.3
	B			-26.06	-$99,958		2.77	$34,649		-0.34	-$1,769
210035	A	Civista 0807	1,889	8	12.6	1,409	2	3.1	1,409	0	0.1
	B			-4.61	-$17,683		-1.08	-$13,509		-0.10	-$520
210037	A	Easton	2,569	20	19.1	1,954	5	3.9	1,954	0	0.2
	B			0.89	$3,414		1.15	$14,385		-0.21	-$1,093
210038	A	Maryland General	2,255	8	12.3	1,260	2	4.2	1,260	0	0.1
	B			-4.29	-$16,455		-2.15	-$26,894		-0.12	-$624
210039	A	Calvert	1,909	8	15.0	1,341	4	2.1	1,341	0	0.1
	B			-7.00	-$26,850		1.93	$24,142		-0.13	-$676
210040	A	Northwest	2,759	13	19.3	1,489	4	5.0	1,489	1	0.2
	B			-6.26	-$24,011		-1.01	-$12,634		0.78	$4,058
210043	A	Baltimore Washington	5,506	41	55.4	3,892	13	10.7	3,892	0	0.5
	B			-14.43	-$55,349		2.30	$28,770		-0.46	-$2,393
210044	A	GBMC	8,580	145	92.2	7,459	4	14.6	7,459	2	0.7
	B			52.80	$202,524		-10.55	-$131,967		1.28	$6,660
210045	A	McCready	66	0	0.9	40	0	0.1	40	0	0.0
	B			-0.89	-$3,414		-0.09	-$1,126		-0.01	-$52
210048	A	Howard	4,155	46	38.2	3,328	2	6.1	3,328	0	0.4
	B			7.81	$29,957		-4.12	-$51,536		-0.39	-$2,029
210049	A	Upper Chesapeake	3,831	36	34.0	2,984	9	6.7	2,984	0	0.3
	B			1.97	$7,556		2.31	$28,895		-0.31	-$1,613
210051	A	Doctors	3,190	24	24.5	1,934	8	5.4	1,934	0	0.2
	B			-0.50	-$1,918		2.57	$32,147		-0.24	-$1,249
210054	A	Southern Maryland	3,965	16	24.8	2,739	2	6.9	2,739	0	0.3
	B			-8.79	-$33,716		-4.92	-$61,543		-0.28	-$1,457
210055	A	Laurel	1,192	5	8.3	806	6	1.8	806	0	0.0
	B			-1.31	-$5,025		4.23	$52,912		-0.04	-$208
210056	A	Good Samaritan	4,789	25	29.7	3,459	7	10.4	3,459	0	0.4
	B			-4.74	-$18,181		-3.37	-$42,154		-0.39	-$2,029
210058	A	Kernan	593	1	1.3	531	1	0.8	531	0	0.0
	B			-0.30	-$1,151		0.23	$2,877		-0.03	-$156
210061	A	Atlantic General	919	8	8.3	736	3	2.3	736	0	0.1
	B			-0.28	-$1,074		0.70	$8,756		-0.10	-$520
210904	A	Hopkins Oncology	633	12	7.7	584	2	1.9	584	1	0.1
	B			4.27	$16,378		0.08	$1,001		0.94	$4,891
		Total	185,642	1,563		149,297	323		149,297	18	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 47			PPC 48			PPC 49		
			$10,182			$10,588			$7,283		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	12,736	22	26.2	13,996	45	34.5	13,807	7	7.1
	B			-4.15	-$42,253		10.51	$111,282		-0.07	-$510
210002	A	University Hospital	22,018	22	67.0	23,248	53	66.9	20,710	13	16.0
	B			-44.97	-$457,864		-13.86	-$146,752		-2.98	-$21,703
210003	A	Prince Georges	10,954	33	14.5	11,762	15	21.7	10,949	3	4.1
	B			18.49	$188,257		-6.68	-$70,729		-1.11	-$8,084
210004	A	Holy Cross	20,996	22	25.6	23,270	18	38.2	22,883	1	8.9
	B			-3.60	-$36,654		-20.20	-$213,881		-7.94	-$57,826
210005	A	Frederick	14,113	33	26.1	15,596	19	35.7	15,403	3	7.0
	B			6.86	$69,845		-16.72	-$177,035		-4.04	-$29,423
210006	A	Harford	6,198	29	8.7	6,835	17	14.1	6,818	3	2.3
	B			20.26	$206,278		2.90	$30,706		0.67	$4,880
210007	A	St. Joseph	19,736	50	50.6	20,979	59	45.4	15,949	18	11.1
	B			-0.59	-$6,007		13.58	$143,788		6.93	$50,470
210008	A	Mercy	14,891	10	21.6	15,401	10	27.1	14,721	2	4.9
	B			-11.57	-$117,801		-17.14	-$181,482		-2.87	-$20,902
210009	A	Hopkins Hospital	26,386	99	76.1	28,602	75	71.0	24,580	35	21.1
	B			22.89	$233,056		3.97	$42,035		13.86	$100,941
210010	A	Dorchester	2,970	1	5.1	3,184	6	6.8	3,158	2	1.2
	B			-4.08	-$41,337		-0.84	-$8,894		0.76	$5,535
210011	A	St. Agnes	15,445	37	33.1	16,716	167	41.0	15,441	11	9.5
	B			3.94	$40,115		126.05	$1,334,642		1.49	$10,851
210012	A	Sinai	19,081	23	44.8	21,170	30	53.7	19,233	13	10.8
	B			-21.75	-$221,449		-23.72	-$251,152		2.20	$16,022
210013	A	Bon Secours	5,276	8	11.3	5,868	6	14.2	5,813	3	3.3
	B			-3.32	-$33,803		-8.20	-$86,823		-0.32	-$2,331
210015	A	Franklin Square	21,763	11	36.8	23,749	19	50.4	23,270	3	11.0
	B			-25.75	-$262,175		-31.41	-$332,575		-7.95	-$57,899
210017	A	Garrett	2,195	0	3.6	2,398	5	5.8	2,370	1	1.1
	B			-3.64	-$37,061		-0.75	-$7,941		-0.08	-$583
210019	A	Peninsula Regional	16,265	29	49.9	18,090	11	45.9	15,131	12	12.7
	B			-20.90	-$212,794		-34.85	-$368,999		-0.65	-$4,734
210023	A	Anne Arundel	18,539	26	30.2	20,291	29	39.3	19,870	8	9.4
	B			-4.17	-$42,457		-10.28	-$108,847		-1.42	-$10,342
210024	A	Union Memorial	17,686	66	55.4	18,475	19	46.4	14,146	3	7.8
	B			10.64	$108,332		-27.37	-$289,799		-4.76	-$34,666
210025	A	Cumberland	6,078	28	9.0	6,723	33	16.3	6,653	7	2.3
	B			18.96	$193,042		16.75	$177,352		4.72	$34,375
210027	A	Sacred Heart	7,340	17	16.2	8,263	14	17.6	7,129	4	5.7
	B			0.78	$7,942		-3.55	-$37,588		-1.68	-$12,235
210028	A	St. Mary's	8,131	6	9.8	8,650	9	15.5	8,624	2	2.6
	B			-3.78	-$38,486		-6.49	-$68,717		-0.56	-$4,078
210029	A	Hopkins Bayview	16,998	15	33.6	18,222	33	43.0	17,592	17	10.0
	B			-18.55	-$188,868		-9.99	-$105,776		7.04	$51,271
210030	A	Chester River	2,809	3	4.4	3,115	4	6.9	3,037	1	1.3
	B			-1.35	-$13,745		-2.91	-$30,812		-0.29	-$2,112
210032	A	Union of Cecil 0907	7,025	15	12.3	7,535	13	16.7	7,502	3	3.1
	B			2.70	$27,490		-3.72	-$39,388		-0.11	-$801
210033	A	Carroll	12,686	5	20.1	14,241	8	31.4	14,044	7	6.3
	B			-15.14	-$154,149		-23.40	-$247,764		0.71	$5,171
210034	A	Harbor	11,065	10	20.8	11,885	19	26.4	11,701	10	5.7
	B			-10.79	-$109,859		-7.35	-$77,823		4.32	$31,462
210035	A	Civista 0807	6,319	5	10.1	6,782	52	14.3	6,718	4	2.9
	B			-5.10	-$51,926		37.74	$399,598		1.10	$8,011
210037	A	Easton	7,584	5	12.7	8,231	17	18.4	7,964	3	4.1
	B			-7.66	-$77,991		-1.37	-$14,506		-1.07	-$7,793
210038	A	Maryland General	8,714	18	17.6	9,688	16	22.1	9,573	9	5.3
	B			0.40	$4,073		-6.13	-$64,906		3.73	$27,165
210039	A	Calvert	6,663	7	8.9	7,114	81	13.0	7,081	3	2.6
	B			-1.94	-$19,752		67.99	$719,891		0.42	$3,059
210040	A	Northwest	10,444	23	23.0	11,725	50	31.0	11,629	6	6.2
	B			0.02	$204		19.00	$201,176		-0.17	-$1,238
210043	A	Baltimore Washington	14,912	74	31.7	16,641	16	43.3	16,244	3	9.8
	B			42.28	$430,476		-27.27	-$288,740		-6.77	-$49,305
210044	A	GBMC	17,420	8	27.8	18,927	56	37.3	18,635	5	7.7
	B			-19.76	-$201,187		18.67	$197,682		-2.65	-$19,300
210045	A	McCready	574	0	0.9	667	0	1.4	666	0	0.2
	B			-0.86	-$8,756		-1.39	-$14,718		-0.17	-$1,238
210048	A	Howard	10,721	43	17.8	11,803	22	22.5	11,625	5	5.7
	B			25.25	$257,084		-0.50	-$5,294		-0.70	-$5,098
210049	A	Upper Chesapeake	12,499	47	19.4	13,726	45	28.3	13,542	4	6.8
	B			27.60	$281,011		16.67	$176,505		-2.75	-$20,028
210051	A	Doctors	9,242	66	17.0	10,385	42	23.3	10,159	10	5.3
	B			49.03	$499,201		18.67	$197,682		4.75	$34,594
210054	A	Southern Maryland	14,512	18	23.3	15,782	24	31.3	15,447	3	5.9
	B			-5.34	-$54,369		-7.25	-$76,764		-2.88	-$20,975
210055	A	Laurel	5,262	15	7.9	6,095	7	12.3	6,087	2	2.5
	B			7.10	$72,289		-5.33	-$56,435		-0.51	-$3,714
210056	A	Good Samaritan	14,230	17	35.5	15,468	14	43.5	14,863	9	8.9
	B			-18.54	-$188,766		-29.45	-$311,822		0.10	$728
210058	A	Kernan	2,190	1	5.5	2,408	6	9.1	2,404	1	1.2
	B			-4.50	-$45,817		-3.14	-$33,247		-0.22	-$1,602
210061	A	Atlantic General	2,981	12	7.2	3,304	8	9.2	3,281	3	1.7
	B			4.79	$48,770		-1.21	-$12,812		1.26	$9,176
210904	A	Hopkins Oncology	799	1	1.2	821	4	4.0	609	1	0.3
	B			-0.19	-$1,934		0.02	$212		0.66	$4,807
		Total	484,446	980		527,831	1,196		497,061	263	

Appendix C
Table 3: Detailed Provider Rates by PPC

Provider	Row	Hospital	PPC 50 $14,138 Number of Cases At Risk	PPC 50 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 50 Row A: Expected Number of Cases Assigned PPC / Row B: Resource Use/Savings	PPC 51 $20,608 Number of Cases At Risk	PPC 51 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 51 Row A: Expected Number of Cases Assigned PPC / Row B: Resource Use/Savings	PPC 52 $8,776 Number of Cases At Risk	PPC 52 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 52 Row A: Expected Number of Cases Assigned PPC / Row B: Resource Use/Savings
210001	A	Washington County	13,821	20	10.7	13,819	8	6.8	13,821	45	22.5
	B			9.33	$131,912		1.17	$24,112		22.48	$197,276
210002	A	University Hospital	22,196	33	29.5	22,881	33	12.0	22,196	76	58.8
	B			3.48	$49,202		20.99	$432,568		17.19	$150,853
210003	A	Prince Georges	11,520	13	7.2	11,671	11	3.6	11,520	47	15.3
	B			5.82	$82,286		7.42	$152,913		31.68	$278,011
210004	A	Holy Cross	22,936	8	12.9	22,969	5	9.2	22,936	40	30.2
	B			-4.91	-$69,420		-4.18	-$86,143		9.85	$86,440
210005	A	Frederick	15,378	6	10.2	15,410	1	7.1	15,378	20	23.2
	B			-4.23	-$59,806		-6.14	-$126,535		-3.18	-$27,906
210006	A	Harford	6,784	3	2.7	6,782	2	2.6	6,784	2	6.8
	B			0.31	$4,383		-0.57	-$11,747		-4.82	-$42,298
210007	A	St. Joseph	19,993	16	22.9	20,726	10	8.0	19,993	42	52.4
	B			-6.91	-$97,697		2.05	$42,247		-10.43	-$91,530
210008	A	Mercy	15,005	9	11.8	15,157	4	3.9	15,005	22	26.8
	B			-2.79	-$39,446		0.10	$2,061		-4.82	-$42,298
210009	A	Hopkins Hospital	27,446	42	37.8	28,019	11	13.6	27,446	75	72.3
	B			4.20	$59,382		-2.58	-$53,169		2.75	$24,133
210010	A	Dorchester	3,131	3	1.6	3,112	4	1.2	3,131	11	3.6
	B			1.40	$19,794		2.77	$57,085		7.42	$65,115
210011	A	St. Agnes	16,272	14	14.6	16,220	20	7.8	16,272	44	33.3
	B			-0.62	-$8,766		12.16	$250,597		10.71	$93,987
210012	A	Sinai	20,465	32	24.0	20,863	16	10.9	20,465	50	46.4
	B			7.99	$112,967		5.15	$106,133		3.58	$31,417
210013	A	Bon Secours	5,661	4	3.6	5,826	3	3.4	5,661	8	10.1
	B			0.42	$5,938		-0.41	-$8,449		-2.06	-$18,078
210015	A	Franklin Square	23,420	7	17.2	23,480	6	10.5	23,420	15	41.5
	B			-10.19	-$144,071		-4.49	-$92,531		-26.50	-$232,554
210017	A	Garrett	2,370	4	1.6	2,371	0	0.9	2,370	0	3.1
	B			2.40	$33,932		-0.86	-$17,723		-3.05	-$26,766
210019	A	Peninsula Regional	17,595	15	24.2	17,922	4	11.6	17,595	16	52.1
	B			-9.15	-$129,367		-7.57	-$156,005		-36.12	-$316,975
210023	A	Anne Arundel	19,899	22	16.5	20,065	5	8.9	19,899	35	32.6
	B			5.55	$78,469		-3.86	-$79,548		2.43	$21,325
210024	A	Union Memorial	17,443	17	22.7	18,340	3	6.8	17,443	40	54.3
	B			-5.65	-$79,883		-3.82	-$78,724		-14.30	-$125,491
210025	A	Cumberland	6,615	8	4.8	6,690	3	2.1	6,615	20	8.9
	B			3.23	$45,667		0.93	$19,166		11.11	$97,497
210027	A	Sacred Heart	8,029	9	7.1	8,161	3	3.0	8,029	18	15.4
	B			1.88	$26,580		0.00	$0		2.64	$23,168
210028	A	St. Mary's	8,560	2	3.7	8,575	1	2.4	8,560	4	8.2
	B			-1.72	-$24,318		-1.35	-$27,821		-4.18	-$36,682
210029	A	Hopkins Bayview	17,706	16	13.7	18,038	3	7.3	17,706	34	30.6
	B			2.29	$32,377		-4.30	-$88,616		3.36	$29,486
210030	A	Chester River	3,080	4	1.9	3,058	1	1.2	3,080	3	4.2
	B			2.09	$29,549		-0.21	-$4,328		-1.17	-$10,267
210032	A	Union of Cecil 0907	7,451	5	4.0	7,408	2	3.2	7,451	7	10.1
	B			0.98	$13,856		-1.15	-$23,700		-3.06	-$26,853
210033	A	Carroll	14,018	7	8.5	14,041	1	5.3	14,018	10	18.4
	B			-1.52	-$21,491		-4.34	-$89,440		-8.36	-$73,364
210034	A	Harbor	11,682	4	8.1	11,720	5	5.1	11,682	16	17.6
	B			-4.13	-$58,392		-0.08	-$1,649		-1.59	-$13,953
210035	A	Civista 0807	6,659	1	3.5	6,698	7	2.4	6,659	8	8.3
	B			-2.52	-$35,629		4.56	$93,974		-0.33	-$2,896
210037	A	Easton	8,049	9	6.2	8,178	0	3.1	8,049	24	11.9
	B			2.76	$39,022		-3.05	-$62,855		12.12	$106,360
210038	A	Maryland General	9,408	8	6.4	9,592	1	5.8	9,408	7	17.3
	B			1.56	$22,056		-4.75	-$97,889		-10.30	-$90,389
210039	A	Calvert	7,022	3	3.6	7,048	2	2.0	7,022	8	7.3
	B			-0.59	-$8,342		-0.03	-$618		0.71	$6,231
210040	A	Northwest	11,485	5	7.7	11,548	5	7.2	11,485	18	20.2
	B			-2.70	-$38,174		-2.15	-$44,308		-2.23	-$19,570
210043	A	Baltimore Washington	16,261	18	13.9	16,294	9	7.7	16,261	28	29.5
	B			4.12	$58,251		1.31	$26,997		-1.46	-$12,812
210044	A	GBMC	18,645	5	14.1	18,465	6	7.9	18,645	32	30.5
	B			-9.13	-$129,084		-1.90	-$39,156		1.48	$12,988
210045	A	McCready	665	0	0.2	663	0	0.3	665	0	0.8
	B			-0.21	-$2,969		-0.26	-$5,358		-0.83	-$7,284
210048	A	Howard	11,661	10	7.7	11,806	4	5.6	11,661	28	17.2
	B			2.35	$33,225		-1.60	-$32,973		10.80	$94,777
210049	A	Upper Chesapeake	13,566	9	9.1	13,620	3	4.9	13,566	12	19.8
	B			-0.05	-$707		-1.94	-$39,980		-7.75	-$68,011
210051	A	Doctors	10,094	13	7.5	10,217	14	5.1	10,094	34	17.0
	B			5.49	$77,620		8.88	$183,002		17.01	$149,273
210054	A	Southern Maryland	15,473	6	8.4	15,619	3	6.6	15,473	12	22.3
	B			-2.36	-$33,367		-3.58	-$73,778		-10.25	-$89,950
210055	A	Laurel	6,038	6	3.6	6,046	4	3.1	6,038	8	8.5
	B			2.45	$34,639		0.94	$19,372		-0.46	-$4,037
210056	A	Good Samaritan	14,962	16	17.0	15,367	6	8.9	14,962	19	35.7
	B			-0.96	-$13,573		-2.89	-$59,558		-16.71	-$146,640
210058	A	Kernan	2,365	4	3.6	2,391	2	2.0	2,365	5	7.7
	B			0.38	$5,373		-0.03	-$618		-2.69	-$23,606
210061	A	Atlantic General	3,237	3	2.6	3,264	2	2.0	3,237	13	5.6
	B			0.45	$6,362		0.01	$206		7.44	$65,291
210904	A	Hopkins Oncology	806	2	2.6	806	1	1.3	806	6	4.1
	B			-0.60	-$8,483		-0.33	-$6,801		1.92	$16,849
		Total	514,872	441		520,746	234		514,872	962	

Appendix C
Table 3: Detailed Provider Rates by PPC

			PPC 53			PPC 54			PPC 56		
			$15,073			$22,295			$2,137		
Provider	Row	Hospital	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings	Number of Cases At Risk	Row A: Actual Number of Cases Assigned PPC Row B: Case Differential	Row A: Expected Number of Cases Assigned PPC Row B: Resource Use/Savings
210001	A	Washington County	13,956	16	16.0	14,661	4	5.9	1,987	19	9.9
	B			0.02	$301		-1.89	-$42,137		9.10	$19,448
210002	A	University Hospital	23,008	65	36.5	26,068	13	15.3	1,467	10	11.7
	B			28.49	$429,420		-2.28	-$50,833		-1.73	-$3,697
210003	A	Prince Georges	11,685	23	9.7	12,224	5	3.4	2,395	13	14.8
	B			13.29	$200,316		1.58	$35,226		-1.80	-$3,847
210004	A	Holy Cross	23,161	12	19.7	25,455	4	8.4	8,589	38	47.4
	B			-7.74	-$116,662		-4.38	-$97,652		-9.41	-$20,111
210005	A	Frederick	15,546	15	16.3	16,220	8	6.4	2,438	3	12.6
	B			-1.30	-$19,594		1.61	$35,895		-9.56	-$20,431
210006	A	Harford	6,823	6	5.8	6,807	2	2.2	0	0	0.0
	B			0.17	$2,562		-0.15	-$3,344		0.00	$0
210007	A	St. Joseph	20,857	15	24.6	20,622	5	8.1	2,155	12	11.5
	B			-9.55	-$143,944		-3.11	-$69,337		0.50	$1,069
210008	A	Mercy	15,250	3	13.3	15,902	0	5.7	2,588	12	14.5
	B			-10.33	-$155,701		-5.65	-$125,967		-2.49	-$5,321
210009	A	Hopkins Hospital	28,297	44	42.7	34,294	30	21.2	1,937	24	16.0
	B			1.26	$18,992		8.82	$196,642		8.01	$17,119
210010	A	Dorchester	3,186	2	2.8	3,153	1	1.1	0	0	0.0
	B			-0.84	-$12,661		-0.05	-$1,115		0.00	$0
210011	A	St. Agnes	16,529	21	19.9	18,275	1	8.2	2,001	13	11.2
	B			1.11	$16,731		-7.22	-$160,970		1.83	$3,911
210012	A	Sinai	21,044	19	25.8	23,084	13	10.3	2,516	40	16.7
	B			-6.75	-$101,740		2.73	$60,865		23.27	$49,731
210013	A	Bon Secours	5,774	12	8.4	5,675	4	3.1	0	0	0.0
	B			3.65	$55,015		0.95	$21,180		0.00	$0
210015	A	Franklin Square	23,613	12	24.4	25,110	9	9.0	2,689	13	16.9
	B			-12.35	-$186,147		0.04	$892		-3.94	-$8,420
210017	A	Garrett	2,391	1	2.4	2,529	0	0.7	266	5	2.2
	B			-1.43	-$21,554		-0.68	-$15,161		2.85	$6,091
210019	A	Peninsula Regional	17,943	12	25.1	18,596	9	10.0	2,224	12	12.1
	B			-13.13	-$197,904		-0.99	-$22,072		-0.07	-$150
210023	A	Anne Arundel	20,177	35	19.2	21,265	7	7.1	5,440	30	28.3
	B			15.79	$237,997		-0.11	-$2,452		1.66	$3,548
210024	A	Union Memorial	18,303	29	23.0	18,106	10	7.6	0	0	0.0
	B			5.97	$89,984		2.44	$54,400		0.00	$0
210025	A	Cumberland	6,694	5	5.1	7,244	0	1.6	1,005	5	7.4
	B			-0.09	-$1,357		-1.61	-$35,895		-2.44	-$5,215
210027	A	Sacred Heart	8,226	7	8.6	8,079	2	2.7	0	0	0.0
	B			-1.64	-$24,719		-0.74	-$16,498		0.00	$0
210028	A	St. Mary's	8,619	1	6.2	9,001	4	2.0	1,107	3	5.5
	B			-5.21	-$78,529		2.01	$44,813		-2.47	-$5,279
210029	A	Hopkins Bayview	18,064	23	19.8	18,658	7	7.5	1,786	19	11.5
	B			3.22	$48,534		-0.52	-$11,593		7.55	$16,135
210030	A	Chester River	3,102	2	2.9	3,282	0	0.9	261	0	1.1
	B			-0.92	-$13,867		-0.91	-$20,288		-1.12	-$2,394
210032	A	Union of Cecil 0907	7,515	3	7.7	7,912	1	2.5	704	2	3.5
	B			-4.69	-$70,691		-1.49	-$33,219		-1.50	-$3,206
210033	A	Carroll	14,175	4	14.1	14,797	1	4.7	1,277	3	7.2
	B			-10.06	-$151,631		-3.66	-$81,600		-4.22	-$9,019
210034	A	Harbor	11,821	1	12.7	12,559	6	4.9	1,636	3	10.1
	B			-11.73	-$176,802		1.11	$24,747		-7.09	-$15,152
210035	A	Civista 0807	6,744	12	6.6	6,918	6	2.3	820	1	3.5
	B			5.38	$81,091		3.72	$82,937		-2.47	-$5,279
210037	A	Easton	8,180	4	7.4	8,577	9	2.7	1,184	10	5.7
	B			-3.43	-$51,699		6.30	$140,458		4.33	$9,254
210038	A	Maryland General	9,576	5	11.7	9,593	4	4.8	1,125	6	8.0
	B			-6.65	-$100,233		-0.83	-$18,505		-2.01	-$4,296
210039	A	Calvert	7,091	2	5.5	7,458	0	1.8	969	3	5.7
	B			-3.45	-$52,001		-1.75	-$39,016		-2.69	-$5,749
210040	A	Northwest	11,659	15	15.1	11,530	2	5.2	0	0	0.0
	B			-0.14	-$2,110		-3.20	-$71,344		0.00	$0
210043	A	Baltimore Washington	16,505	21	20.3	16,883	8	7.1	1	0	0.0
	B			0.75	$11,304		0.88	$19,620		0.00	$0
210044	A	GBMC	18,800	31	18.8	19,632	18	7.3	4,613	24	28.5
	B			12.25	$184,640		10.72	$239,002		-4.51	-$9,639
210045	A	McCready	665	0	0.6	667	0	0.2	0	0	0.0
	B			-0.61	-$9,194		-0.17	-$3,790		0.00	$0
210048	A	Howard	11,730	28	12.6	12,643	8	4.8	3,129	25	17.7
	B			15.41	$232,270		3.25	$72,459		7.34	$15,687
210049	A	Upper Chesapeake	13,686	10	12.9	14,527	0	4.5	1,551	5	6.3
	B			-2.89	-$43,560		-4.48	-$99,881		-1.27	-$2,714
210051	A	Doctors	10,245	30	12.8	10,148	4	4.3	0	0	0.0
	B			17.21	$259,400		-0.27	-$6,020		0.00	$0
210054	A	Southern Maryland	15,652	17	14.5	16,096	4	5.4	1,782	7	9.3
	B			2.55	$38,435		-1.35	-$30,098		-2.30	-$4,915
210055	A	Laurel	6,062	4	6.2	6,075	0	1.9	586	0	3.4
	B			-2.23	-$33,612		-1.85	-$41,246		-3.35	-$7,159
210056	A	Good Samaritan	15,295	12	20.6	15,063	11	6.8	0	0	0.0
	B			-8.63	-$130,077		4.21	$93,862		0.00	$0
210058	A	Kernan	2,403	2	3.2	2,441	0	0.8	0	0	0.0
	B			-1.19	-$17,936		-0.78	-$17,390		0.00	$0
210061	A	Atlantic General	3,279	6	4.1	3,268	0	1.4	0	0	0.0
	B			1.86	$28,035		-1.43	-$31,882		0.00	$0
210904	A	Hopkins Oncology	813	0	1.4	1,011	2	0.8	0	0	0.0
	B			-1.44	-$21,705		1.18	$26,308		0.00	$0
		Total	524,124	587		552,108	222		62,208	360	

Appendix D
Table 4: Hospital PPC Rankings

Hosp ID	Name	Using All PPCs					
		At Risk Inpatient Revenue	% of At Risk Revenue	Rank	Total Inpatient Charges	% of Total Inpatient Charges	Rank
210045	McCready Memorial Hospital	$4,865,205	-5.71%	1	$5,412,998	-5.13%	1
210033	Carroll Hospital Center	$122,265,308	-3.24%	2	$139,922,153	-2.83%	2
210027	Braddock Hospital	$67,581,048	-3.22%	3	$80,585,254	-2.70%	4
210028	St. Mary's Hospital	$60,163,481	-3.14%	4	$67,932,719	-2.78%	3
210008	Mercy Medical Center	$157,835,394	-2.96%	5	$193,272,957	-2.42%	5
210056	Good Samaritan Hospital	$172,516,189	-2.63%	6	$201,247,143	-2.26%	6
210017	Garrett County Memorial Hospital	$16,265,235	-2.42%	7	$18,579,636	-2.12%	7
210015	Franklin Square Hospital Center	$235,088,284	-2.20%	8	$285,311,249	-1.81%	8
210038	Maryland General Hospital	$107,777,422	-2.17%	9	$139,985,425	-1.67%	9
210013	Bon Secours Hospital	$56,162,746	-2.11%	10	$69,062,126	-1.71%	10
210034	Harbor Hospital Center	$122,060,440	-1.97%	11	$147,120,540	-1.63%	11
210054	Southern Maryland Hospital Center	$133,986,519	-1.91%	12	$157,458,438	-1.62%	12
210040	Northwest Hospital Center	$104,376,194	-1.35%	13	$120,249,766	-1.17%	13
210024	Union Memorial Hospital	$272,139,235	-1.32%	14	$311,765,277	-1.15%	14
210007	St. Joseph Medical Center	$241,905,297	-1.28%	15	$278,356,211	-1.11%	15
210005	Frederick Memorial Hospital	$136,060,092	-1.06%	16	$162,689,511	-0.89%	16
210019	Peninsula Regional Medical Center	$214,005,509	-0.97%	17	$257,066,029	-0.81%	17
210023	Anne Arundel Medical Center	$198,394,266	-0.90%	18	$235,711,681	-0.75%	18
210037	Memorial Hospital at Easton	$72,236,008	-0.78%	19	$87,104,876	-0.65%	19
210032	Union of Cecil	$54,686,369	-0.73%	20	$62,894,394	-0.64%	20
210029	Johns Hopkins Bayview Medical Center	$220,735,037	-0.64%	21	$280,398,118	-0.50%	21
210044	GBMC	$171,125,088	-0.60%	22	$204,992,823	-0.50%	22
210904	Hopkins Oncology	$20,147,932	-0.54%	23	$156,069,939	-0.07%	24
210043	Baltimore Washington Medical Center	$157,965,637	-0.23%	24	$185,136,502	-0.19%	23
210039	Calvert Memorial Hospital	$53,826,325	0.25%	25	$60,215,646	0.22%	25
210009	Johns Hopkins Hospital	$666,182,598	0.45%	26	$893,679,304	0.33%	26
210004	Holy Cross Hospital	$233,562,653	0.53%	27	$287,513,451	0.43%	27
210049	Upper Chesapeake Medical Center	$113,678,423	0.70%	28	$131,032,728	0.61%	28
210012	Sinai Hospital	$320,920,932	0.75%	29	$393,865,136	0.61%	29
210061	Atlantic General Hospital	$32,476,185	1.07%	30	$37,224,856	0.93%	30
210011	St. Agnes Hospital	$189,348,020	1.22%	31	$229,196,700	1.01%	31
210058	James Lawrence Kernan Hospital	$39,119,430	1.23%	32	$46,791,845	1.03%	32
210010	Dorchester General Hospital	$22,521,118	1.25%	33	$26,999,472	1.04%	33
210001	Washington County Hospital	$127,841,557	1.63%	34	$158,362,125	1.31%	34
210025	Memorial of Cumberland	$59,467,450	1.93%	35	$68,007,429	1.69%	36
210006	Harford Memorial Hospital	$50,104,863	2.14%	36	$56,213,844	1.91%	37
210002	University of Maryland Hospital	$530,562,602	2.19%	37	$862,721,990	1.35%	35
210048	Howard County General Hospital	$114,847,481	2.66%	38	$137,988,774	2.22%	38
210030	Chester River Hospital Center	$28,119,631	2.80%	39	$32,175,064	2.45%	39
210035	Civista Medical Center	$55,425,877	3.47%	40	$66,866,283	2.88%	40
210003	Prince Georges Hospital Center	$126,865,954	7.37%	41	$167,898,373	5.57%	41
210055	Laurel Regional Hospital	$55,081,915	7.45%	42	$63,393,989	6.47%	42
210051	Doctors Community Hospital	$87,673,611	8.66%	43	$107,903,095	7.03%	43

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

May 13, 2009

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

This represents a draft recommendation of HSCRC staff to the Commission at the May 13, 2009 public meeting of the Commission. Any comments should be submitted to Robert Murray, HSCRC Executive Director, on or before Wednesday, May 27, 2009.

Staff Draft Recommendations on Request for HSCRC Financial Support of Maryland Patient Safety Center in FY 2010

Background

The 2001 General Assembly passed the "Patients' Safety Act of 2001,"charging the Maryland Health Care Commission (MHCC), in consultation with the Department of Health and Mental Hygiene (DHMH), to study the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland including, but not limited to, a system of reporting such incidences. The MHCC subsequently recommended the establishment of a Maryland Patient Safety Center (MPSC or Center) as one approach to improving patient safety in Maryland.

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

The operators of the MPSC were chosen through the State of Maryland's Request for Proposals (RFP) procurement process. At the request of MHCC, the two respondents to the RFP to operate the MPSC, the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva), agreed to collaborate in their efforts. The RFP was subsequently awarded jointly to the two organizations for a three-year period (January 2004 through December 2006). The RFP authorizes two one-year extensions beyond the first three years of the pilot project. MHCC extended the contract for two years ending December 31, 2009. The Center was subsequently re-designated by MHCC as the state's patient safety center for an additional five years – through 2014.

In 2004, the HSCRC adopted recommendations that made it a partner in the initiation of the MPSC by providing seed funding through hospital rates for the first three years of the project (FY 2005-2007). The recommendations provided funding to cover 50% of the reasonable budgeted costs of the Center for each of those fiscal years. The Commission annually has received a briefing and documentation on the progress of the MPSC in meeting its goals as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on these presentations, staff evaluated the reasonableness of the budget items presented and made recommendations to the Commission.

In June of 2007, the HSCRC adopted recommendations to continue to provide funding for 50% of the reasonable budgeted costs of the Center (less any carry-over) in FY 2008 and FY 2009.

Over the past 5 years, the rates of eight Maryland hospitals were increased by the following amounts, and funds have been transferred on a biannual basis (by October 31 and March 31 of each year):

- FY 2005 - $ 762,500
- FY 2006 - $ 963,100

- FY 2007 - $1,134,980
- FY 2008 - $1,134,110
- FY 2009 - $1,927,927

Maryland Patient Safety Center Request to Extend HSCRC Funding

On May 4, 2009, the HSCRC received the attached request for continued financial support of the MPSC through rates in FY 2010 (Attachment 1). The request offered several funding options over the next four fiscal years which include:

- Continuing the 50% match on expenditures;
- Reducing the rate setting system contribution by $100,000 each year;
- Reduce the percentage to 45% in FY 2010
- Reduce the percentage to 40% in FY 2010 and reduce that percentage by 5% in each of the next 3 years.

The Table below represents the revenue impact of each of these options in FY 2010 based on an expected budget of $3,669,500 (including a $29,900 carryover from FY 2009):

FY 2010 Funding Options

	FY2009 projected	FY 2010 – 50% of exp.	FY 2010 - $100,000 reduction	FY 2010 – 45% of exp.	FY 2010 – 40% of exp.
Members*	$612,000	$705,000	$705,000	$705,000	$705,000
HSCRC	$1,927,927	$1,834,750	$1,827,927	$1,651,275	$1,467,800
Grants/Donat.	$911,935	$1,129,750	$1,136,573	$1,313,225	$1,496,700
Total	$3,451,862	$3,669,500	$3,669,500	$3,669,500	$3,669,500

Maryland Patient Safety Center Purpose, Accomplishments, and Outcomes

The purpose of the MPSC is to make Maryland's healthcare the safest state in the nation focusing on the improvement of systems of care, reduction of the occurrences of adverse events, and improvement in the culture of patient safety at Maryland health care facilities. The MPSC's new strategic plan directs concentration on the following 6 areas:

- Measurement of vision success and program impact;
- Patient and family voices at all levels;
- Institutions create and spread excellence;
- Institutions safety culture hardwired;
- Continuity of care initiatives; and
- Demonstrate the value of safety.

Below is a general description of the various initiatives put in place by the MPSC to accomplish the aforementioned goals as well as estimated outcomes and expected savings of each initiative.

1. Adverse Event Information System and Data Analysis

The Center has developed software that it has provided to hospitals free of charge to be used as a fully operational adverse event data collection tool. However, hospitals may report adverse events and near misses by using their existing software. Data collected through the project may be used to benchmark events against other facilities as well as to explore trends and patterns relating to the types of events occurring at hospitals. This knowledge will assist MPSC and Maryland hospitals to develop standardized best practices to prevent or reduce the number of adverse events occurring in the future.

The Commission has also provided additional funding to MPSC to design and conduct a survey on health information technology. The survey is intended to assist the Commission in understanding how technologies improve the effectiveness of disease treatment and patient management as well as to ascertain the efficacy of different types of technology. The MPSC will continue to work with both the HSCRC and the MHCC in developing and updating the findings for this survey.

2. Patient Safety Education Programming

The MPSC has conducted, free of charge, a series of educational programs designed to train leaders and practitioners in the health care industry and share strategies to improve patient safety and quality. These programs have focused on the following areas:

- Patient safety tools training including root cause analysis;
- Management development;
- Process improvement including LEAN workshops and Six Sigma certification;
- TeamSTEPPS Train the trainer programs;
- Sharing information on MedSAFE, hospital information technology, and patient falls; and
- Leadership issues.

These programs, particularly the LEAN and Six Sigma programs are designed to improve efficiency and reduce costs at hospitals and nursing homes. It is estimated that hospitals can save between $250,000 to $1 million per year depending on the application and breadth of such programs.

3. MEDSAFE Medication Safety Initiative

The MEDSAFE program was initiated by the Maryland Hospital Association has been in existence since 1999. After being moved to the MPSC, the Initiative continues to promote the implementation of safe medication practice at Maryland hospitals. The

Safe Medication Practices' Medication Safety Self-Assessment tool is used to survey hospitals and develop customized reports. The survey solicits responses from individuals at hospitals across various hospital departments on more than 200 questions relating to the level of compliance with evidence-based practices aimed at reducing medication errors.

Outcomes: In 2002, hospitals scored between 41%-82% on the survey. In 2006, the scoring range has increased to 50%-93%.

4. Patient Safety Collaborative Program

The MPSC has initiated a series of Collaboratives focused on the implementation and development of safe practices and culture change in high hazard settings. The Center's collaborative workshops bring together Maryland providers and national experts to focus on safety culture and specific process improvements, with the goal of implementing measurable and sustained improvement. The following Collaborative programs have been implemented by the Center:

ICU Safety and Culture Collaborative

The ICU Collaborative, which ran from 2005 to 2007, included teams from thirty-eight of Maryland hospitals' intensive care units. The program was aimed at eliminating preventable death and illness associated with healthcare-associated blood stream infections (BSI) and pneumonia in patients on ventilators.

Outcomes: Since this was the first Collaborative implemented by the MPSC, data is available to estimate the benefits of the project to date:

- ICUs at 5 hospitals met the challenge of zero ventilator-associated pneumonia episodes;
- Overall, ventilator-associated pneumonia has been reduced by 20% in participating ICUs;
- An estimated 755 ventilator-associated pneumonia infections have been prevented – based on statistical modeling; it is estimated that about 75 lives have been saved, reducing hospital costs by about $35 million;
- Ten hospitals achieved zero catheter-associated BSI episodes;
- Catheter-associated BSI have been reduced by 36%;
- An estimated 358 BSI infections have been avoided – based on statistical modeling, it is estimated that about 62 lives have been saved thereby reducing hospital costs by about $5 million;
- In total, an estimated 1,113 ventilator associated pneumonia or catheter-related blood stream infections have been prevented, saving approximately 140 lives, and resulting in about $40 million in cost savings at hospitals each year.

Emergency Department Collaborative

The Emergency Department Collaborative began in 2006 and continued through 2007. This Collaborative was conducted with the intent of improving emergency room

flow and getting time-sensitive treatments to patients quickly. Twenty-nine multi-disciplinary teams representing over half of the hospitals in the State worked towards achieving a broad spectrum of ambitious goals geared towards ensuring that the sickest ED patients get the care they need quickly, and that all patients are cared for in a timely manner with the smallest possible exposure to preventable healthcare associated harm. As a starting point, the collaborative teams implemented a series of change strategies that have been recommended in the scientific literature or reported as successful by other hospitals.

A Handoff and Transition Network has grown out of the discussions of the ED Collaborative. A handoff or patient transition in care from one provider to another, involves the transfer of information, primary responsibility, and authority among providers. In hospitals, handoffs take place on admission, during shift and unit changes, before and after procedures, and at discharge. According to a Joint Commission evaluation of root cause analyses, communication problems caused 70% of sentinel events in accredited healthcare organizations. The Handoff and Transfer Network continues to focus on efforts to improve medication reconciliation and hospital flow as patients move into and through hospital departments and then back to the community.

Since the inception of the Network, 80% of facilities have initiated a formal handoff process, and 65% have adopted an improved format (known as "Trip Ticket") for patient handoffs for procedures such as radiological procedures as well as for other tests.

Outcomes: Based on a sample of 748,237 patients seen during a one-year period at 15 participating hospitals, median length of stay has been reduced by 30 minutes saving about 374,000 hours. The median number of visits per treatment space has increased by 90 visits. In addition, ambulance diversions have been reduced at many participating hospitals - 24% hospitals reduced yellow alert times, and 48% reduced red alert time. It is estimated that 189 additional pneumonia patients were given an antibiotic during the appropriate time frame. This is estimated to save $130,000 in hospital costs, or, on average, $688 per patient.

MRSA Pilot Project

Baltimore has had the highest known rate of healthcare and community acquired Methicillin-resistant *Staphylococcus Aureus* (MRSA) in the country (116 cases per 100,000). This project builds upon the "Prevention of Hospital-Associated MRSA Infection" project that began in July 2006. The MPSC began addressing the MRSA issue using an "asset-based" behavior change approach called "Positive Deviance" – this is a way of tapping into the wisdom of people on the front lines to solve seemingly intractable problems. During the first phase, the MRSA project focused its efforts on the work and relationships among hospitals and the healthcare and community-based facilities that are the source of many MRSA infections. The next phase, based on new science, is to encourage facilities to continue to screen their patients for asymptomatic carriers in ICUs and expand this surveillance more widely.

Expected Outcomes: A Centers for Disease Control analysis found that "Positive Deviance" can reduce MRSA incidences by up to 62%.

Perinatal Collaborative

The Perinatal Collaborative began in September 2006 and will run through FY 2009. This collaborative includes participation from 25 labor and delivery units at Maryland hospitals. The mission of the Collaborative is to create perinatal units that deliver care safely and reliably with zero preventable adverse outcomes. The goal is to reduce infant harm through the implementation and integration of systems improvements and team behaviors into maternal-fetal care using various proven methods.

The collaborative selected an Adverse Outcome Index to follow improvements in outcomes between 2006 and 2007.

Outcomes: Admission to the NICU (for >2500 grams, >37 weeks gestational age for more than 24 hours) declined by 19.3% despite a 1.5% increase in births over the data period. Maternal returns to the OR declined by 16%. The study involves about 77% of all births in Maryland and Washington, D.C.

5. New Projects

Patient Falls

Data collected by MPSC over the past two years indicate that patient falls are the second most frequently occurring, event after medication errors; however, patient falls rank first in terms of severity. The MPSC intends to reduce the number of patient injuries resulting from falls by developing standardized protocols using best practices and testing them over time.

In October 2008, 12 hospitals, 11 long term care facilities, and five home health agencies agreed to pilot falls prevention Roadmaps. MPSC will expand the program in FY 2010 by rolling out the toolkit and data collection statewide to all settings. MPSC will also conduct a focused study on 15 facilities in Maryland to evaluate the severity of falls they are reporting to better estimate the costs savings.

Expected Outcomes: Reducing the rate of falls by 5% at Maryland hospitals is expected to save $1.5 million annually.

Pressure Ulcers

Pressure ulcer rates in Maryland currently exceed the national average – 13.1% in Maryland versus 12% nationally. While the difference is not significant, over the past 4 years, the rate has declined by 13% nationally but only by 3% in Maryland. The cost of managing a single full-thickness pressure ulcer can be as high as $70,000.

Maryland has a significant opportunity for improving pressure ulcer rates as well as costs due to the following conditions:

- Among the 233 nursing homes in Maryland, over 5,000 residents may develop a new pressure ulcer this year, and 2,685 pressure ulcers may develop among hospital patients.
- Liability claims per occupied bed have increased at an annual rate of 14%, while the average court settlement has risen to $250,000.

Recognition

In September of 2005, the Maryland Patient Safety Center was honored with the 2005 John M. Eisenberg Patient Safety and Quality Award for national/regional innovation in patient safety. The John M. Eisenberg Award was established in 2002 by the National Quality Forum (NQF) and The Joint Commission in memory of John M. Eisenberg MD, Director of the Agency for Healthcare Research and Quality, a member of the founding Board of Directors of the NQF, and an impassioned advocate for healthcare quality improvement. This annual award perpetuates the contributions of this health care and community leader by recognizing, among other things, the achievement of individuals and organizations who, through a specific initiative or project, have made an important contribution to patient safety and health care quality in the areas of research or system innovation.

In 2009, the Center was re-designated by MHCC as the state's patient safety center – continuing its relationship with the State. In addition, the Center is now listed as a federal Patient Safety Organization (PSO).

Change in Board and Structure

As per the RFP that created it, the Maryland Patient Safety Center is a single, not-for-profit entity that serves as a data repository for a voluntary, de-identified adverse event and a near miss reporting system for all health care facilities statewide. It also serves as the primary coordinator for educational activities focused around patient safety issues. To operate the Center, MHCC selected a partnership of LogicQual Research Institute, a subsidiary of MHA, and the Delmarva Foundation. The contractors, in compliance with the RFP, established an Advisory Board to facilitate the dissemination of the recommended practices as well as relevant peer-reviewed literature on patient safety and the results of root cause analyses to encourage organizational change within Maryland health care facilities.

In order to operate more effectively, the Center has altered its leadership structure to include a new fiduciary Board of Directors and was granted not-for-profit 501(C)(3) organization status.

Staff Recommendations

The All-Payer System has supported the Maryland Patient Safety Center during its initial five years with the expectation that there would be both short-term and long-term reductions in hospital costs – particularly as a result of reduced mortality rates, lengths of stays, patient acuity, and malpractice insurance costs. The activities of the MPSC have now begun to result in discernable positive outcomes for patients, which

have been demonstrated to achieve costs savings at Maryland hospitals. A goal of the MPSC should be to ensure that such outcomes and related cost savings are sustained after the collaborative networks and educational programs have concluded.

HSCRC staff believes there to be potential for further reductions in hospital costs through continued education and collaborative networking. Further, there is value in allowing the MPSC to continue its work as one component of a broad patient safety initiative to improve quality of care by reducing adverse health events at Maryland hospitals and nursing homes. In order to do so, the Center requires continued financial support and is requesting that the All-Payer system continue to fund a portion of its budgeted expenditures for FY 2010 and into the future.

Staff believes that this endeavor continues to be consistent with the HSCRC Quality Initiative. Commission staff is confident that the MPSC will continue to bring Maryland closer to achieving the health care quality goals expressed by both the MHCC and the HSCRC by reducing medical errors and improving clinical and administrative efficiency. The research and better practices that result from the operation of the MPSC will likely assist the Commission, as it continues to consider criteria, measures, and benchmarks for the HSCRC Quality-based Reimbursement Initiative. These initiatives together provide a unique opportunity to improve both health care outcomes and, at the same time, reduce costs in the health care system.

Staff is encouraged to see that the Center is implementing a strategic fund raising plan to ensure financial sustainability into the future. Because of the current economic outlook, staff believes obtaining other private and public funding will be challenging in FY 2010 – especially given the timing of initiating the fund raising plan. Given existing cost savings at Maryland hospitals, along with the potential for more in the future, staff finds value in having the HSCRC continue to be a minority partner in this initiative. However, as the strategic fund raising plan gains momentum, staff proposes that the All-Payer System's financial commitment gradually decline until such commitment reaches 25% of the Center's budgeted expenses (but not to exceed the previous year's dollar commitment). The pace of this decline will be determined on an annual basis, following further review.

Therefore, after reviewing the accomplishments and financing of the MPSC, staff believes that the All-Payer System should continue to be a partner in the funding of the MPSC in FY 2010 and into the future. Specifically, staff makes the following recommendations:

- **In FY 2010, funding should be provided through hospital rates to cover 45% of budget costs of the Center, less 50% of any carry-over from the previous year. The expected carry over from FY 2009 is $29,900. Therefore, staff recommends providing funding through the All-Payer System in the amount of $1,636,325 (or $1,651,275 - $14,950).**

- **For future years, the percentage of budgeted costs covered through hospital rates should be reduced by at least 5% per year, but in no year shall the funding (on a dollar basis) exceed the amount provided in the previous year.**

The percentage decline shall be determine annually based on a continued review of MPSC activities which shall take into account the existence of demonstrable evidence of improved outcomes, efficiency, and cost savings resulting from MPSC's programs, as well as the viability and success of MPSCs strategic fund raising plan.

- **Since staff believes that there is value in the HSCRC continuing to be a minority partner with the MPSC, it is the intent that funding decline over time but to maintain a reasonable base level of support (potentially 25% of budgeted costs). The pace at which such a floor should be reached shall be determined based on annual reviews of MPSC activities, taking into account the existence of demonstrable evidence of improved outcomes, efficiency, and cost savings resulting from MPSC's programs, as well as the viability and success of MPSCs strategic fund raising plan.**

- **The MPSC should update the Commission periodically on health care outcomes and expected savings resulting from the programs sponsored by the Center. As collaborative networks and educational programs expire, the MPSC should track the sustainability of any positive outcomes achieved as a result of its work and determine whether other outcomes emerge over time.**

- **The MPSC should aggressively pursue other sources of revenue to help support the Center into the future.**

Attachment 1

Maryland Patient Safety Center
FY2010 Program Plan & Budget

FY2010 MPSC Program Plan & Budget: Implementing a Strategic Agenda for Keeping Patients Safe

Presented to

HSCRC
Health Services Cost Review Commission

May 2009

Maryland Patient Safety Center

A collaboration between the Maryland Hospital Association and Delmarva Foundation for Medical Care

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Executive Summary

The Maryland Patient Safety Center (MPSC) maintains a relentless pursuit of innovative approaches to make medical errors a thing of the past. In its five year history, MPSC, its partners, and providers have taken many impressive strides and seen improvements. However, to paraphrase President Obama, we are pleased with our progress, but, knowing that errors continue to occur, much work remains.

MPSC, providers, and the state have developed a strong foundation on which to grow and further ensure patient safety in our communities. With this Fiscal Year 2010 Program Plan & Budget, we request a continued commitment to and investment in patient safety on the part of the Health Services Cost Review Commission. The plan includes strategic programming that works across care settings, engages patients, measures improvement, and retains support for successful programs. In addition, MPSC is launching a strategic fundraising initiative entitled the *Keeping Patients Safe Campaign* that will reach out to a diversified set of funding organizations and businesses to support the work of the Center.

Key highlights and successes include:

- **100% of Maryland hospitals** participate, and an increasing number of long term care, home health, and other care settings enroll in MPSC events and programs.
- Program data from the **Perinatal Learning Network show improved quality of care for mothers and babies,** including:
  - Admission to the NICU (for >2500 grams, >37 weeks gestational age for more than 24 hrs) declined by 19.3% despite a 1.5% increase in births for the follow-up period. This translates to **88 more moms going home with their babies** in the follow-up period. MPSC is studying the savings that may be associated with this change.
  - Returns to the OR/L&D declined by 16%. This translates to **12 mothers not having to return for additional care** during the follow-up period.
  - Hospitals are implementing policies to reduce elective inductions prior to 39 weeks gestational age, a step that is associated with **reduced risks and complications**.
  - Hospitals involved represent **77% of births in Maryland and Washington DC.**
- MPSC will launch a statewide, multi-setting initiative to **reduce falls**. In addition to avoiding injury and suffering, falls result in costly complications for patients. Examining hospitals alone, MPSC's targeted annual 5% reduction in the rate of falls will **save an estimated $1.5 million annually** upon full rollout of the program.
- MPSC's Lean and Six Sigma training offers a method to revolutionize and standardize routine processes. A recent Lean event targeted medication safety and delivery. Final analysis is underway, but significant **cost savings**, efficiencies and safety improvements were observed regarding inventory reduction, turnaround time, and workflow in one facility alone, with potential savings ranging from $250,000 - $1 million.
- **Improved outcomes and processes**, including reductions in ventilator associated pneumonia and catheter-related blood stream infections during the Intensive Care Unit Collaborative,

resulting in an estimated 1,113 infections prevented, 140 lives saved, and $40,775,070 avoided hospital costs.

- Maryland has shown landmark improvement in hospital mortality from 2005 to 2007, key years in which MPSC initiated its efforts. In a recent national survey of hospital mortality, Maryland had the second lowest risk-adjusted mortality rate, **and was among the most improved in mortality rates in the nation** (16.5% improvement from 2005-2007).[i]
- Maryland hospital leaders endorse the Center, and, in a recent survey, identified MPSC as the most effective and important healthcare initiative underway in the state.
- MPSC is the recognized national leader in state and regional patient safety efforts. MPSC continues to offer the most comprehensive set of innovative programs and success of any state patient safety center in the country.
- The Maryland Health Care Commission re-designated MPSC as the state's patient safety center for an additional five years, through 2014.
- MPSC was listed as a federal Patient Safety Organization (PSO), and was selected by the Agency for Healthcare Research and Quality to be highlighted as a model PSO at the National Patient Safety Foundation Annual Conference in May 2009.
- MPSC was honored with the 2005 John M. Eisenberg Patient Safety and Quality Award for national/regional innovation in patient safety. The award recognizes the achievement of individuals and organizations that have made an important contribution to patient safety and health care quality in research or system innovation.
- MPSC is engaging consumers – patients and families – as partners in patient safety.

Thank you for your willingness to review MPSC's progress to date and plans for the future. The following report provides an overview of the Center's achievements, describes specific programs and approaches, and summarizes the strategic next steps that are creating a sustainable infrastructure for patient safety improvement in Maryland. We look forward to a continued partnership in these efforts with the Health Services Cost Review Commission.

William Minogue, MD, FACP
Executive Director
Maryland Patient Safety Center

Overview & Impact

MPSC has charted a course for innovative improvement in healthcare quality and patient safety. Programs have expanded both as a result of current year operations and the new MPSC Strategic Plan, which calls for a focus on:

- Measurement of Vision Success & Program Impact
- Patient & Family Voices at All Levels
- Institutions Create & Spread Excellence
- Institutions' Safety Culture Hardwired
- Continuity of Care Initiatives
- Demonstrate the Value of Safety

MPSC: Making Maryland's Healthcare the Safest in the Nation

- Innovative programs with high uptake among healthcare providers
- Convener of local and national leaders to improve the quality of care
- Data-driven study of adverse events to set priorities and enable safety
- Education programs provide a foundation of skills and knowledge
- Clinical improvement in priority areas
- Focus on cross-setting improvement

Multiple high-profile programs have been launched in the past year, including a TeamSTEPPS Learning Network, the Neonatal Collaborative, and the SAFE from FALLS Pilot. All have demonstrated strong support of and need for the cooperative and regionally-oriented programs that MPSC uniquely offers.

MPSC seeks continued support of its core operations and programs. This includes a statewide rollout of the SAFE from FALLS program, launch of a pressure ulcer prevention initiative, management of a series of Advisory Councils to shape and implement innovative programming, amplified efforts to formally enroll healthcare providers across the continuum of care in MPSC programs, and targeted measurement tracking. We believe that the six strategic areas provide the cornerstone for continued engagement in and success of MPSC programs.

In 2008, the Center completed a strategic reorganization, becoming an incorporated organization with the Maryland Hospital Association and the Delmarva Foundation continuing to act as primary members of the Center. A newly-designated voluntary Board of Directors has participated in setting a strategic long-term agenda for MPSC. In addition:

- The Internal Revenue Service has granted the Maryland Patient Safety Center status as a tax-exempt 501(c)(3) organization
- The Maryland Health Care Commission re-designated the Center for an additional five years, through 2014
- MPSC became listed as a Federal Patient Safety Organization
- MPSC has received local and national recognition for its model and programs

These are critical achievements in the Center's ability to support Maryland's relentless quest to provide effective, safe and efficient care for our citizens.

The following provides some key highlights from MPSC's activities and programs that describe participation, improvements, projected cost savings, and local and national recognition.

Participation & Support

- **100% of Maryland hospitals** participate, and an increasing number of long term care, home health, and other care settings enroll in MPSC events and programs.
- Perinatal Collaborative: Twenty-six of the 33 hospitals (79%) in Maryland offering obstetrical services are involved in the Collaborative, representing **77% of births in Maryland and Washington DC.**
- ED Collaborative: Teams from 61% (28 out of 46) of Emergency Departments in Maryland representing nearly **65% (1,076 out of 1,682) of the state's emergency department treatment spaces.**
- ICU Collaborative: Teams from 83% (38 out of 46) of Maryland hospitals representing nearly 90% **(799 out of 893) of the state's intensive care unit beds.**
- Educational Programs: Over **11,000 hospital and long-term care providers trained** in safety practices and/or involved in targeted improvement programs.
- MPSC engages facility **Patient Safety Officers** in bimonthly focused meetings to discuss and address patient safety topics.
- MPSC's outreach to long term care associations, national campaigns and organizations, consumer organizations, and others, in addition to partnership with hospitals and Delmarva, creates a robust base of support for Center and state initiatives.

"We in Maryland are very lucky to have this. There may not be anything like it in the country; if we aren't the first, we were one of the first to create this type of center. The Center deserves every award they get for striving toward safe patient care."

- Mary Jozwik, Vice President for Quality and Patient Safety, Baltimore Washington Medical Center

Improvement

- Maryland has shown landmark improvement in hospital mortality from 2005 to 2007, key years in which MPSC initiated its efforts. In a recent national survey of hospital mortality, Maryland had the second lowest risk-adjusted mortality rate, and was among the most improved in mortality rates in the nation (16.5% improvement from 2005-2007).[ii]
- **Improved outcomes and processes**, including reductions in ventilator associated pneumonia and catheter-related blood stream infections during the Intensive Care Unit Collaborative, resulting in an estimated 1,113 infections prevented, 140 lives saved, and $40,775,070 avoided hospital costs.
- **Program data from the Perinatal Collaborative & Learning Network show improved quality of care for mothers and babies, including**
  - Admission to the NICU (for >2500 grams, >37 weeks gestational age for more than 24 hrs) declined by 19.3% despite a 1.5% increase in births for the follow-up period. This translates to **88 more moms going home with their babies** in the follow-up period. MPSC is studying the savings that may be associated with this change.
  - Returns to the OR/L&D declined by 16%. This translates to **12 mothers not having to return for additional care** during the follow-up period.
  - Hospitals are implementing policies to reduce elective inductions prior to 39 weeks gestational age, a step that is associated with **reduced risks and complications**.

- Emergency Department program data reveal that during the course of the program:
  - **189 (out of 3,779) additional pneumonia patients** were given antibiotic on-time.
  - **$130,032 hospital costs avoided.** Additional length of stay associated with not getting antibiotic on-time equals 0.4 days. Using 2006 hospital pricing guide the state average cost per day for pneumonia admission is $1,721. So each additional patient given the antibiotic on-time saves 0.4 day, which would save $688 per patient.

Projected Savings

- Building on MPSC's pilot Falls program, MPSC will launch a statewide initiative that will include hospitals, nursing homes, and home health agencies. In addition to avoiding injury and suffering, falls result in costly complications for the patients. Examining hospitals alone, MPSC's targeted annual 5% reduction in the rate of falls will **save an estimated $1.5 million annually** upon full rollout of the program.
- MPSC offers the healthcare community access to tools and resources used in the business community in an effort to prevent waste in the healthcare system. A recent Lean/Six Sigma event targeted medication safety and delivery. Final analysis is underway, but significant **cost savings**, efficiencies and safety improvements were observed regarding inventory reduction, turnaround time, and workflow in one facility alone, with potential savings ranging from $250,000 - $1 million.
- Poor communication among providers is the #1 underlying reason for medical errors and contributes to suffering for patients and costly litigation to providers. MPSC's innovative and successful Teamwork and Communication training program focuses on the skills needed to **make these errors a thing of the past.**

Recognition

- Maryland hospital leaders endorse the Center, and, in a recent survey, identified MPSC as the most effective and important healthcare initiative underway in the state.
- MPSC is the recognized national leader in State and regional patient safety efforts. MPSC continues to offer the most comprehensive set of innovative programs and success of any state patient safety center in the country.
- The Maryland Health Care Commission re-designated MPSC as the state's patient safety center for an additional five years, through 2014.
- MPSC was listed as a federal Patient Safety Organization (PSO), and was selected by the Agency for Research and Quality to be highlighted as a model PSO at the National Patient Safety Foundation Annual Conference in May 2009.
- The Maryland Patient Safety Center was honored with the 2005 John M. Eisenberg Patient Safety and Quality Award for national/regional innovation in patient safety. The award recognizes the achievement of individuals and organizations that have made an important contribution to patient safety and health care quality in research or system innovation.

"What makes the Maryland Patient Safety Center unique from just about every other patient safety program in the country is that the state gave it a mandate to innovate and go beyond data collection to actually putting practical, measurable safety

Implementing a Strategic Agenda

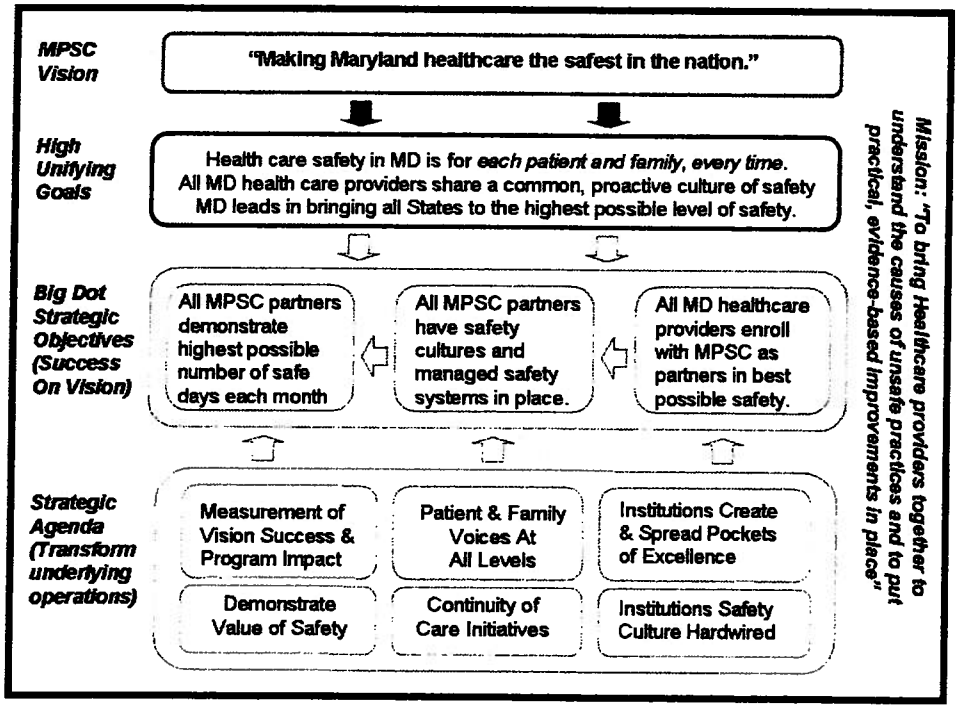
Through a participatory planning process, the MPSC engaged its Board of Directors, external stakeholders and partners, healthcare community representatives, and staff to contribute to the strategic plan of the Center. MPSC staff interviewed each Board member, gaining many rich insights that resulted in a shared vision and focused the strategic agenda on six main areas:

1. Measurement of Vision Success & Program Impact
2. Patient & Family Voices at All Levels
3. Institutions Create & Spread Excellence
4. Institutions Safety Culture Hardwired
5. Continuity of Care Initiatives
6. Demonstrate the Value of Safety

MPSC applied these six strategic agendas to:

1. Assess the extent to which current programs address these patient safety areas; and
2. Identify new program opportunities based on the strategic agendas.

Below is a graphic representation of the mission, vision and strategic agendas. A summary of each strategic agenda is in Attachment A. Each strategic agenda has an MPSC Board member as a champion.



Program Details

MPSC and its partners, including the Delmarva Foundation and the Maryland Hospital Association, design and carry out a series of innovative and influential programs that are helping meet the mission of making Maryland's healthcare the safest in the nation. The following describes a set of new and enhanced programs, such as the SAFE from FALLS Statewide Rollout, as well as ongoing programs, such as the Perinatal Learning Network and the Adverse Event Reporting System, offered by MPSC.

New and Enhanced Programs

SAFE from FALLS Statewide Rollout

Injuries from falls can lead to significant morbidity and mortality. Data submitted to the MPSC Adverse Event Reporting system reveals that falls are among the predominant patient safety issues for patients and facilities. In addition, the Maryland Office of Health Care Quality has found that patient falls make up the greatest proportion of reported adverse events that result in serious injury or death in hospitals. The Centers for Disease Control and Prevention (CDC) reports that nearly one-third of U.S. adults ages 65 and older fall each year (CDC, 2008). MPSC's SAFE from FALLS Initiative aims to reduce the prevalence of, and the severity of injury resulting from, falls in all settings, while contributing significantly to the regional and national knowledge base on this critical topic.

In October 2008, 12 hospitals, 11 long term care facilities, and five home health agencies agreed to pilot falls prevention Roadmaps. MPSC will **expand the program in FY2010 by rolling out the toolkit and data collection statewide to all settings**. MPSC will simultaneously conduct a **focused study** of fifteen Acute Care Centers, Long Term Care Facilities, and Home Health Agencies in Maryland to evaluate the severity of falls they are reporting to better estimate the **cost savings**.

A recent Business Case Analysis found there to be significant cost savings from reducing falls statewide. A 5% reduction in falls with injury would lead to a $285,517 saving per month statewide. If we use the estimate of 1.5 falls per patient year, the savings would be $1.5 million per year statewide. This information is a sound basis for a Statewide Fall Reduction Campaign via the SAFE from FALLS Roadmap.

Neonatal Collaborative

The successful Maryland Patient Safety Center Perinatal Collaborative unleashed a heightened recognition and new urgency from the neonatal community for a similar initiative aimed at addressing preventable harm among infants receiving care in Level II (special care) and level III (neonatal intensive care) nurseries. A generous grant from CareFirst® BlueCross® BlueShield® in the amount of $635,000.00 was awarded to MPSC on December 17, 2007 and will continue to support this work through June 2010.

Twenty-two hospital teams from Maryland, Northern Virginia, and the District of Columbia have completed participation agreements. The first Learning Session will be held in June 2009. An Expert Panel guided the aims of the Neonatal Collaborative, which are to:

- Reduce healthcare-associated infection by 50% through the implementation of evidence-based prevention care practices
- Decrease neonatal morality by 10%, chronic lung disease by 10%, and length of stay by 10% through standardized resuscitation and stabilization of the neonate in the first hour of life (Golden Hour)
- Improve teamwork and communication through the implementation of team behaviors, including the family, into neonatal care as measured by the Agency for Healthcare Research and Quality (AHRQ) Hospital Patient Safety Survey. Fifty percent (50%) of participating neonatal units will improve their perception of safety at one year.

Pressure Ulcer Initiative

MPSC is in the planning stages of a major initiative that will work across the continuum of care to address the issue of pressure ulcers. Pressure ulcer rates in Maryland continue to exceed the national average. MPSC's effort garners the participation and support of long-term care settings, home care providers, hospitals, and agency nursing organizations. Historically, improvement efforts targeting pressure ulcers have not addressed multiple care settings, though providers across all settings are concerned with this issue. Using a plan piloted in Minnesota as a starting point, MPSC's initiative will add an innovative and replicable model to the national dialogue.

Maryland has significant opportunity for improving pressure ulcer rates

- Maryland's pressure ulcer rate is 13.1% compared to the national average of 12%.
- Over the past several years, the national pressure ulcer rate has declined by 13% compared to a 3% decline in Maryland.
- Among the 233 nursing homes in Maryland, over 5,000 residents may develop a new pressure ulcer this year, and 2,685 pressure ulcers may develop among hospital patients.
- Liability claims per occupied bed have increased at an annual rate of 14 percent, while the average court settlement has risen to $250,000 dollars.

State of the State Measurement Plan

Among the strategic goals of MPSC is the systematic depiction of the state of safety in Maryland and advancing the cause of measurement. MPSC's February 2009 briefing before the Maryland Senate Finance Committee resulted in a specific request for this report. MPSC recognizes that this effort is critical to demonstrating the state of healthcare in Maryland and the impact of the Center. Toward this goal, a Board sub-committee was formed to draw the blue-print for action on how to measure two critical dimensions needed to build a state of the state profile. These dimensions are:

1. Constructing a conceptual design for a dashboard of safety
2. Assessing the role MPSC plays in changing practices toward safer care

Well-defined and targeted areas of impact measurement are expected to be identified

in order to establish actual or potential links between MPSC activities (collaborative projects, special studies, educational programs, adverse events analysis, among others) and changes in practice patterns, or prevalence of undesirable events. MPSC recognizes that in the first year of the State of the State it will likely be necessary to focus on hospital statistics, but will examine ways to include other care settings in the first year, with plans to expand this area significantly in future years.

MPSC Advisory Councils

In Fiscal Year 2009, MPSC convened two workgroups to assist with multidisciplinary program planning in the areas of Falls and Pressure Ulcers. In Fiscal Year 2010 (July 2009-June 2010), MPSC plans to convene targeted and ongoing Advisory Councils in the following areas:

- Patient & Family Voices
- Culture & Leadership Engagement
- Continuum of Care, with a primary focus on Pressure Ulcers

MPSC is widely recognized as a **successful convener** of stakeholders, creating the opportunity to identify and deploy improvement in areas of common patient safety need. MPSC sees these Advisory Councils as critical drivers of improvement and change that will assist MPSC and other leaders in the State in formulating and implementing programs that will have regional impact. In addition, MPSC representatives serve on a number of crucial regional panels and initiatives, linking MPSC's efforts into other comprehensive initiatives, including:

- Governor's Health Care Quality & Cost Council
- Delmarva Quality Improvement Patient Safety Community of Practice
- MHCC Hospital Performance Evaluation Guide Advisory Committee
- MHCC Committee on Healthcare-Associated Infections

Ongoing Programs

Perinatal Learning Network

Collaboratives usually are 12-18 months in duration. Permanently improving complex systems takes much longer. In addition, participants in all MPSC Collaboratives have become close colleagues and have requested that we continue to support their efforts. Therefore, in FY2009, MPSC extended the work of the Perinatal Collaborative by adding a learning network phase. The aim of the Perinatal Learning Network is to reduce maternal and infant harm through the implementation and integration of systems improvements and team behaviors into maternal-fetal care. Funding has been generously extended by the Center for Maternal and Child Health, Department of Health & Mental Hygiene (DHMH) through June 2010 to ensure support for ongoing data collection.

With the kick-off of the Perinatal Collaborative in March 2007, a substantial infrastructure of obstetrical (OB) and neonatal professionals was established. Participants now represent 25

hospitals in Maryland and 2 in the District of Columbia which includes two new teams that joined the Network in 2008—Sibley Memorial Hospital and University of Maryland Medical Center.

Harm will continue to be measured using the Adverse Outcomes Index (AOI). The AOI is a new tool for measuring obstetrical outcomes. Maryland is the first state in the country applying the AOI to improvement activities. The baseline period for measurement was calendar year 2006. The follow-up period was October 2007 through August 2008.

Notable improvements in OB indicators for Level 1 & 2 hospitals include:

- 21% decrease in uterine rupture
- 24% decrease in maternal admissions to the ICU
- 22% decrease in birth trauma
- 23% decrease in returns to the OR/L&D

For Level III hospitals, notable improvements include:

- 17% decrease in uterine rupture
- 13% decrease in returns to the OR/L&D
- 23% decrease in admissions to the NICU for babies >2500 g with a greater than 24 hour stay.

Over 70% of the hospitals improved staff perception of teamwork and communication and more than 60% improved the overall perception of safety. Beginning in December 2008, the Network began collecting process measure data on the number of inductions and C-sections less than 39 weeks gestational age without a medical indication. For babies less than 39 weeks, there are increased risks of complications. The Network is currently gathering baseline data with a goal of reducing these deliveries.

Condition H

A Rapid Response Team (RRT) is a team of clinicians that brings immediate attention and critical care expertise to a patient whose condition appears to be deteriorating with the goal of decreasing mortality of hospitalized patients. A Condition Help program empowers patients and/or family members who become concerned with the patient's status to initiate a call for immediate help from the facility's Rapid Response team. This project was inspired by Sorrel King and is funded by CareFirst BlueCross BlueShield. Eight "early adopter" hospitals that demonstrated excellence with RRT implementation were recruited to pilot patient- and family-initiated Condition Help calls.

To date, six of the eight facilities recruited to participate in the collaborative have piloted and/or fully implemented the patient-and-family activation component to their rapid response teams. The other two participating facilities are in the planning process for their Condition H programs. In the next year, a toolkit will be further refined and promoted regionally to garner greater uptake of the Condition H model in the region.

MRSA Learning Network

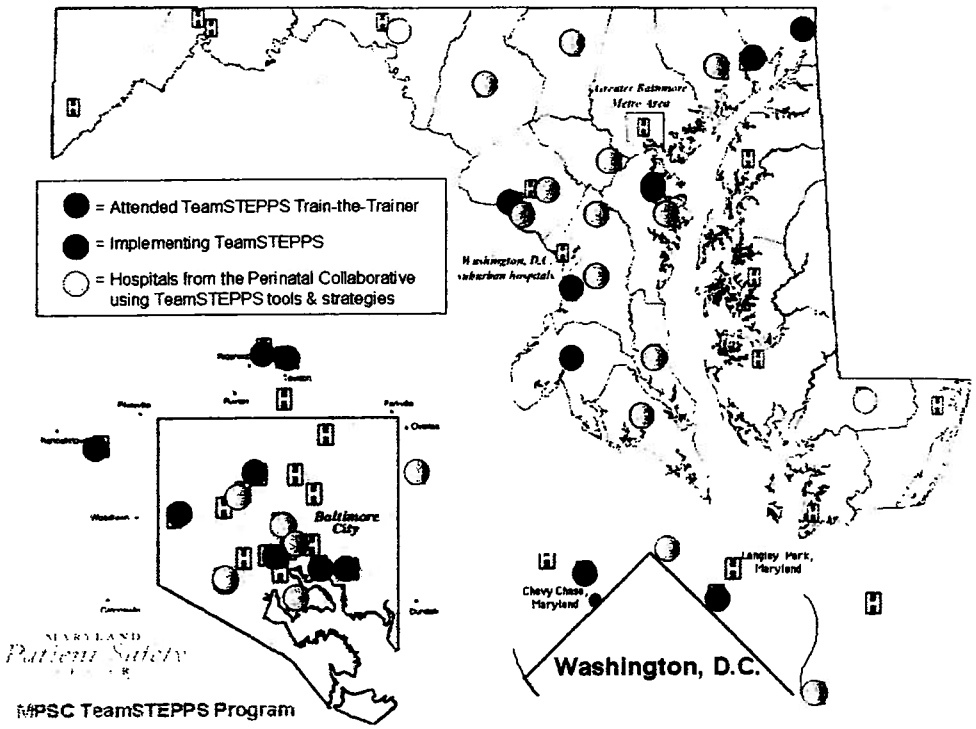
MPSC's Methicillin resistant Staphylococcus aureus (MRSA) initiative began more than two years as a pilot project. Two Maryland hospitals were part of a Robert Wood Johnson grant using a change approach called Positive Deviance (PD) based on the discovery of innovations at the grass roots level. In applying this approach, a CDC analysis has found significant reductions of up to 62 percent in the incidence of MRSA. The second phase expanded using PD to 30 hospitals, long-term care facilities, and dialysis centers. Throughout the project participating facilities have sent data to the CDC's NHSN, the results of which will be available in fall 2009.

The next phase, based on new science, is to encourage facilities to continue to screen their patients for asymptomatic carriers in ICUs and expand this surveillance more widely. The MRSA Learning Network will continue to master hand hygiene, isolation and other barrier precautions and add other resistant organisms to the portfolio

TeamSTEPPS™ Learning Network

Improving teamwork, especially in clinical teams, may be the single most important cultural change that is needed to make a significant improvement in patient safety. MPSC has adopted TeamSTEPPS™ training, made available by AHRQ, as its recommended methodology for improving clinical teamwork and communication. There is a substantial amount of evidence that poor cooperation and communication is a primary cause of error in any team in any industry. After several disastrous crashes, the military and commercial airlines adopted a "crew resource management" concept to develop effective teams where communication is open and frequent. It has contributed to the airline industry having significant improvements in its safety record. TeamSTEPPS™ is an application of that concept to healthcare.

MPSC's program, launched in 2008, takes users step-by-step through implementation, detailing the roadmap for creating change and shifting the organization toward a sustained culture of safety. There is great local interest in these innovative tools. The map at right depicts the spread and uptake of TeamSTEPPS™ concepts since MPSC initiated the program.



Education Programs

Education is one of the primary strategies the MPSC uses to improve the adoption of safer practices in Maryland hospitals and nursing homes. The Maryland Healthcare Education Institute (MHEI), an affiliate of the MHA, carries out a comprehensive series of educational offerings on behalf of the Center. The MPSC's educational activities have been designed to achieve the following goals:

- Create awareness of the need for improved patient safety and of the cultural changes required for significant improvements.
- Ensure that healthcare leaders have the competencies essential for safety improvement.
- Disseminate patient safety solutions and best practices.
- Create a safety-oriented culture in organizations by focusing leadership on key issues and concepts
- Serve as a catalyst and convener for best practices and solutions in patient safety.

Participation in the programs has included acute care hospitals (65%), healthcare systems (10%), specialty hospitals (8%), long-term-care facilities (7%), and other providers (9%). The programs fall into several categories outlined below.

Process Improvement Programs

The aim of the Process Improvement Programming is to give participants in-depth competencies in how to improve specific systems and processes so that processes can be made both more efficient and safer. There is no question that hospitals and all healthcare organizations are under significant pressure to provide safer care, improve clinical quality, and cut costs through more efficient operations. For example, a week-long Lean process improvement event in April 2009 is estimated to result in savings of $250,000 - $1 million in one facility alone.

The combination of Lean and Six Sigma methodologies provides a comprehensive set of strategies to address these issues. Lean's origin is in Japanese performance improvement techniques, especially the Toyota Production System. Six Sigma is an evolution of the Continuous Quality Improvement (CQI) tools and strategies, with a greater degree of statistical use. The key is to drive out waste and improve safety through Lean use, and continually refine performance through Six Sigma methodologies. These are state of the art tools that are in use by industries throughout the world, and are increasingly being adopted by healthcare organizations. FY2010 plans include a thorough evaluation of the impact of the Process Improvement programming as a whole.

Professional Development Programs

There are many topics in patient safety that need to be addressed in more depth, targeting the skills, information, and tools that professionals can apply immediately to their work. The Professional Development Series is designed to meet that need, and is designed for patient safety officers, other patient safety professionals, and department heads. The programs are structured as workshops with a limited audience so that significant interaction and practice can occur.

The programs provide tools to address important topics in patient safety, such as:

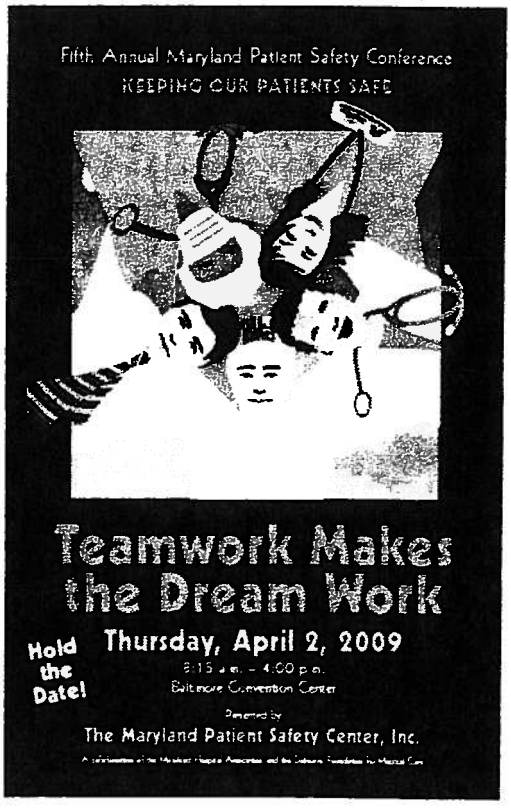
- Specific tools to address potential conflicts between accountability and just cultures.
- Reinforce skills for leaders to use in engaging patients and families.
- How do we advance innovation? How do we sustain improvement? The answer to those questions is vital to patient safety improvement.

Patient Safety Tools Training

Health care facilities spend considerable time improving processes and yet untoward events still happen. Why? Because often process changes are not directed at the latent conditions that cause people to make mistakes. In this series of four, one-day workshops, healthcare managers and professionals learn how to determine if the fundamental system deficiencies that precipitated an untoward event have been found, how to develop sustainable corrective actions to prevent similar incidents in the future, and how to build systems so that errors are prevented proactively. They'll also discover why traditional process improvements have failed to eliminate the risk of untoward events and what safeguards are needed to prevent simple errors from causing accidents.

The aim of these popular courses is to enable widespread adoption of the basic tools of patient safety. The programs are each offered multiple times to reach a broad healthcare audience, ensuring that:

- Root Cause Analysis (RCA) is understood by a significant number of healthcare managers and professionals.
- Maryland Office of Health Care Quality (OHCQ) requirements for RCA are understood.
- Failure Mode & Effects Analysis (FMEA) is understood and applied as a methodology for proactively building safe systems.



Annual Conference

The Annual Maryland Patient Safety Conference is the MPSC's signature event of the year. It provides awareness, specific education, and best practice solutions to a broad-based audience that goes well beyond MPSC usual participants. The purpose is to spread the patient safety message to a broad-based audience, present best solutions, and involve the whole audience in teamwork to move the patient safety agenda forward.

The April 2009 Conference was the fifth and drew an audience of over 1,500 participants from health systems, hospitals, long term care facilities, home care agencies, health insurers, research institutions, and nursing and allied

health schools. In addition to the keynote speech by John J. Nance, JD, there were 24 concurrent sessions in the following day-long tracks: Accountability, Best Solutions, Leadership, Professional Issues, Specialty, and Special Interest.

Remarkably, each year MPSC receives more and more submissions to the Directory of Solutions, which each conference participant receives, with almost a twofold increase in submissions from 2008 (56) to 2009 (102). This represents strong interest in the Solutions approach, shows a willingness to share, and, most importantly, demonstrates a focused and growing commitment to patient safety efforts among providers in the region.

Adverse Event Reporting System

MPSC's Adverse Event Reporting System (AERS) was designed to gather data on all patient safety incidents, particularly near miss events that offer great opportunity for learning. The data are used to explore patterns and trends related to patient safety events and near misses that occur in healthcare facilities. The software is owned by the Center for Performance Sciences, an affiliate of MHA, which provides the flexibility to tailor and refine the program to meet the needs of the users and to react to trends in the healthcare community. AERS is the mechanism by which participants can report data to MPSC.

The system was designed to assist health care entities to determine their own organizational strategic priorities, focus organizational efforts toward improving processes, and promote safer patient care practices. The plans for FY2010:

- Reflect expanded project management support and oversight of the Adverse Event Reporting System
- Reflect revision of the tool according to national standards being developed by AHRQ through the Patient Safety Organization (PSO) network
- Incorporates an Expert Panel and, as appropriate, a User Group to provide oversight and input on the system
- Involves support from clinical and statistical experts

As one of the 56 federally-listed PSOs, MPSC offers the most comprehensive set of programs supporting adverse event reporting of any similar organization in the country. The AERS is a complementary system to the mandatory reporting of adverse events resulting in death or serious disability to the Maryland Department of Health and Mental Hygiene as it captures voluntary reporting of information on adverse events and near misses.

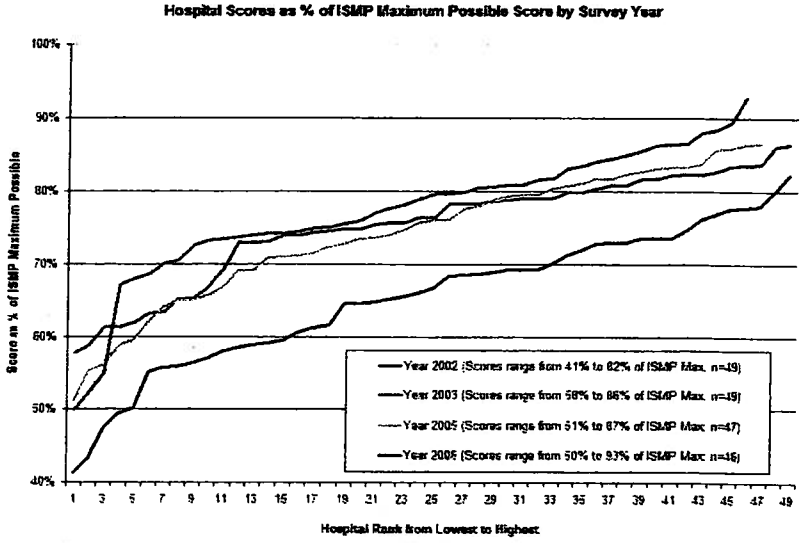
Research Programs

The research arm of the MPSC adds a synthesizing function by evaluating new knowledge from the field and complementing it with findings from MPSC's various activities. In particular, research activities have focused on the MEDSAFE program, the first statewide hospital health information technology (HIT) survey, and analysis of data from the Adverse Event Reporting System, described previously.

MEDSAFE

The MEDSAFE initiative to study medication safety started in 1999 with the voluntary participation of all Maryland acute care hospitals. The program was transferred to MPSC, and continues to promote and study the implementation of safe medication practices in facilities. It both assesses better practices of medication use and is an educational initiative for sharing these practices among hospitals. MEDSAFE continues to be a very valuable service of the Center. After almost a decade of assistance to Maryland hospitals, the survey has identified significant improvement in medication safety, as shown in the graphic to below, as well as gaps between actual and optimal performance.

The program implementation team and the Maryland Healthcare Education Institute use the data to design an annual conference aimed at sharing best practices and emerging innovations in this area. A scientific paper about MEDSAFE will be published in Spring 2009 in a peer reviewed journal. In FY2010, MPSC will explore a pilot of this effort with long-term care organizations.



Health Information Technology

There is convincing evidence of an enabling association between Health Information Technology (HIT) uses and improvement in the quality and safety of care. To establish a base of HIT availability and use across Maryland hospitals, the MPSC conducted a survey in 2007 funded by the Health Services Cost Review Commission (HSCRC). As expected, hospitals are at various levels of adopting, implementing or using HIT. The survey process and findings were well received by hospital leadership and information system representatives. Therefore, MPSC will conduct an annual survey of HIT, identifying trends and linking them to safety of care improvement strategies.

The recent focus on HIT and the potential availability of Federal funds to help providers adopt necessary HIT have raised awareness among Maryland providers and government agencies about the integral role of HIT in performance improvement. In particular, the Maryland Health Care Commission (MHCC) has been given the task to conduct a statewide HIT survey as a component of their hospital performance measurement mandate. Discussions between the MPSC, HSCRC and MHCC have been launched to streamline the HIT survey, data analysis, and provider education efforts. Preliminary ideas include conducting a joint MPSC and MHCC statewide HIT survey in the fall of 2009, to be followed by a conference in Spring 2010.

MPSC Core Administration

MPSC's core operations include shaping and implementing innovative programming, amplified efforts to formally enroll healthcare providers across the continuum of care in MPSC programs, further fund development, and targeted measurement tracking. We believe that the six strategic areas and the planned Advisory Councils provide the cornerstone for engagement in and success of MPSC's ongoing programs.

MPSC's Core Administration staff manage and implement a number of key activities intended to ensure oversight of the numerous programs and initiatives of the center, management of relationships with internal and external stakeholders, supporting governance activities, fund development, communication activities, and others.

In addition to requiring that all programs implement and report on key metrics, MPSC has engaged a committee of the Board to assist in designing a system for demonstrating the State of the State in patient safety as well as a dashboard for monitoring MPSC's success. In addition to working with the Board and internal stakeholders, MPSC plans to engage a third party consultant to guide the process as an external evaluator. MPSC's Core Administration staff include an Executive Director/President, a Director of Operations and Development, and an Executive Assistant.

Fundraising Plan – Keeping Patients Safe Campaign

MPSC is committed to financial sustainability for the Center. This sustainability will result in part from the quality and impact of the work conducted by the Center, and also from a strategic initiative to raise supporting dollars for the Center from a diversified set of sources.

MPSC has begun implementing a Strategic Fundraising Plan (SFP), designed to be the roadmap guiding MPSC toward achievement of the organization's FY2010-2012 development objectives. The plan is based on the organization's vision, mission, objectives, strategic plan, and funding requirements. The SFP focuses efforts around the *Keeping Patients Safe Campaign*. The *Keeping Patients Safe Campaign* builds on existing and planned MPSC programs that will be continued or initiated in FY2010-2012. It creates an identifiable umbrella for MPSC's funding efforts and programs.

Fundraising strategies included in the SFP are those felt holding the greatest potential for success in light of available resources. It includes detailed action plans outlining tasks/activities to be carried out, assigning responsibilities for task execution, and establishing a timeline for the completion of assigned tasks.

MPSC will convene a Campaign Task Force chaired by an opinion leader. MPSC and its Board can attract such a leader – a corporate CEO, major sports figure, politician, or other public figure. The Task Force's immediate objective is to raise a minimum of $2 million to support and kick-off the *Keeping Patients Safe Campaign*.

Budget

Maryland Patient Safety Center
FY 09 Projection and FY 10 Budget Request

	FY 09 Budget	FY 09 Projection	FY 10 Budget
MPSC Beginning Unrestricted Fund Balance	587	(33,962)	29,900
REVENUE			
Cash Contributions from MHA/Delmarva	400,000	400,000	400,000
Cash Contributions from Hospitals	200,000	212,000	230,000
HSCRC Funding*	1,927,927	1,927,927	1,651,275
Restricted Grants (Carefirst, DHMH)	955,800	825,530	848,250
Other Funding-Mixed Sources	85,000	80,000	75,000
Interest Income	15,000	6,405	6,500
Total Revenue	**3,583,727**	**3,451,862**	**3,211,025**
EXPENSES			
Administration	601,300	615,000	637,800
Adverse Event Information System	345,895	340,000	374,100
Patient Safety Education Programming	566,295	560,000	571,800
MEDSAFE Medication Safety Initiative	40,000	55,000	67,500
Patient Safety Collaborative/Learning Sessions	2,002,950	1,703,000	1,736,800
Research	190,000	50,000	82,450
Measurement	-	-	111,050
Public Website/Communications	60,000	60,000	58,000
Contingency Reserve	50,000	5,000	30,000
Total Expenses	**3,856,440**	**3,388,000**	**3,669,500**
MPSC Ending Unrestricted Fund Balance	(272,127)	29,900	(428,575)

* HSCRC FY2010 request is equal to 45% of the FY2010 Expense Budget. This represents a reduction from the FY2009 request of $276,652. Alternative scenarios are attached.

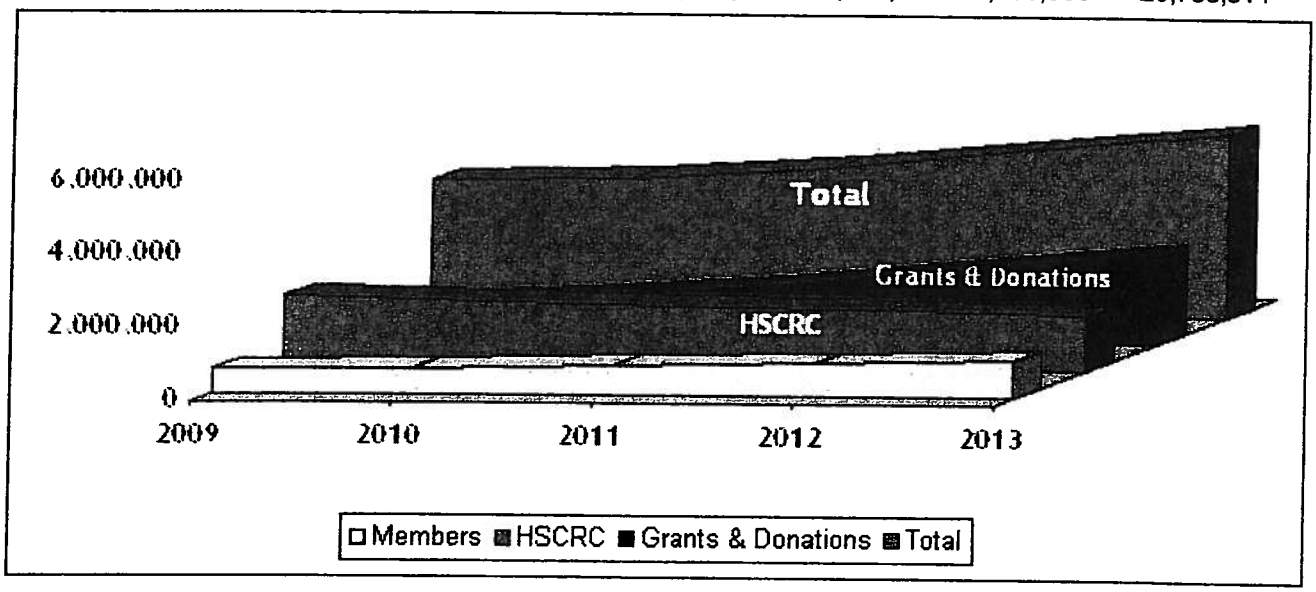
The budget shortfall ($428,575) represents the minimum of the required funding that MPSC will raise as part of the *MPSC Keeping Patients Safe Campaign*

Funding Projections/Scenarios

Included below are three funding scenarios based on estimated budgets for FY2010-2013.

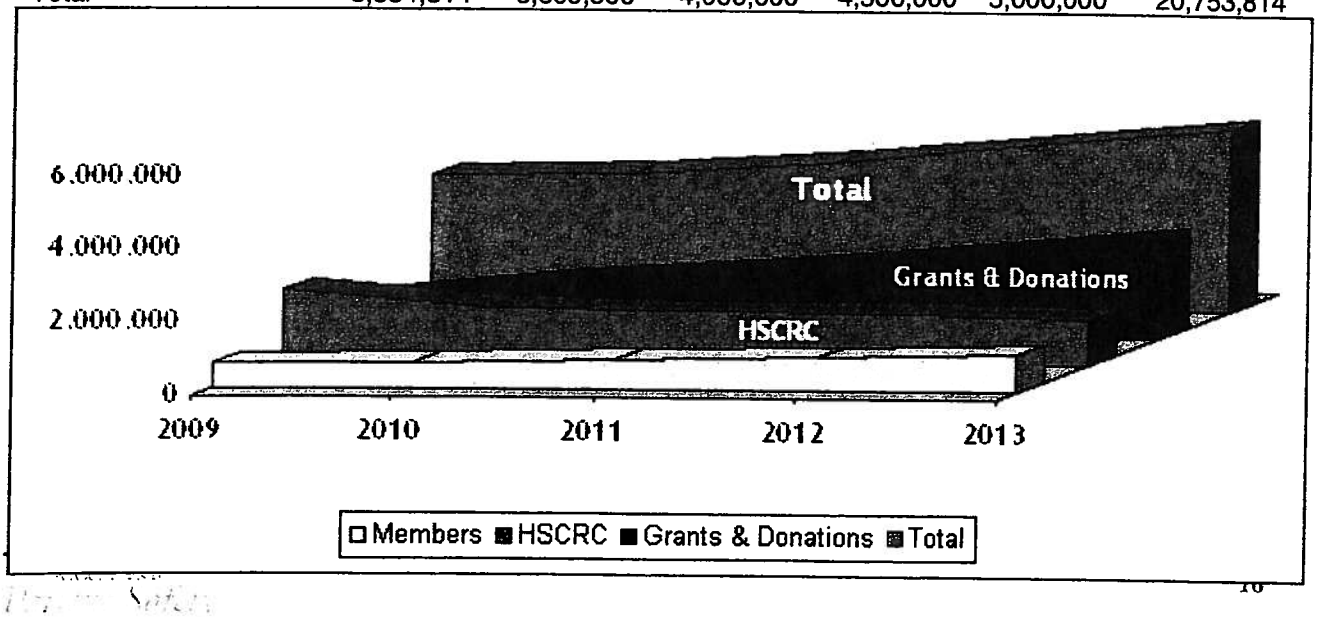
Scenario 1: Gradual Drop of HSCRC support (-$100,000 per year)

	2009	2010	2011	2012	2013	Total
Members	685,000	705,000	800,000	900,000	1,000,000	4,090,000
HSCRC	**1,927,927**	**1,800,000**	**1,700,000**	**1,600,000**	**1,500,000**	**8,527,927**
Grants & Donations	971387	1,164,500	1,500,000	2,000,000	2,500,000	8,135,887
Total	3,584,314	3,669,500	4,000,000	4,500,000	5,000,000	20,753,814



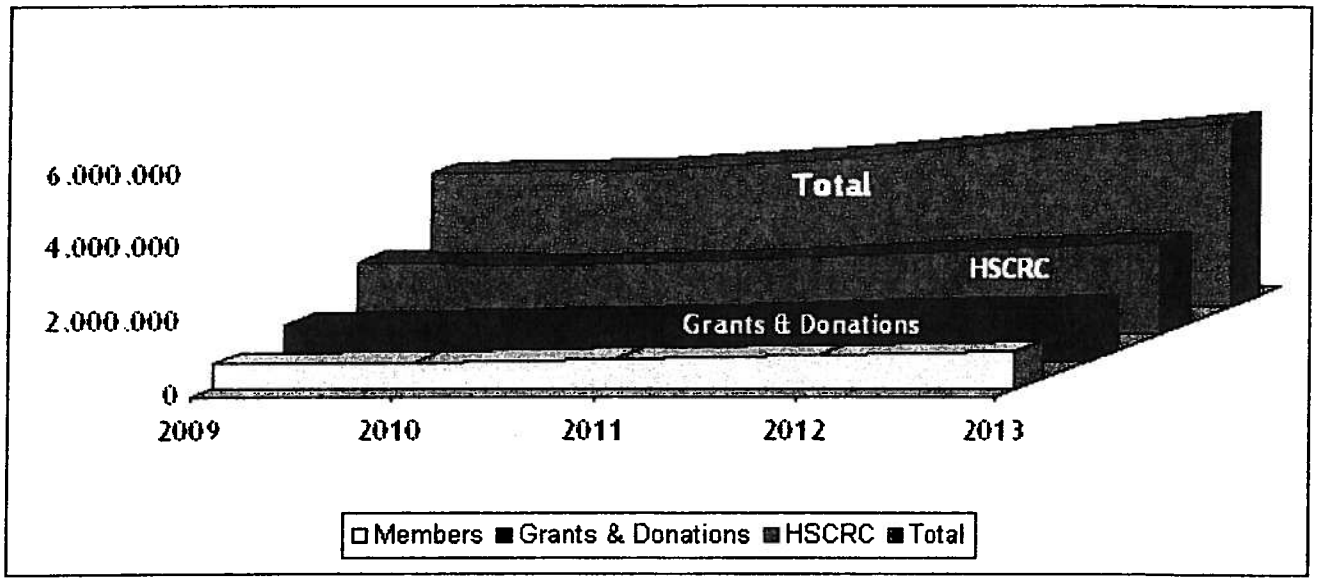
Scenario 2: HSCRC support at 40% match of Expenses in FY10, -5% per year thereafter

	2009	2010	2011	2012	2013	Total
Members	685,000	705,000	800,000	900,000	1,000,000	4,090,000
HSCRC	**1,927,927**	**1,467,800**	**1,400,000**	**1,350,000**	**1,250,000**	**7,395,727**
Grants & Donations	971387	1,496,700	1,800,000	2,250,000	2,750,000	9,268,087
Total	3,584,314	3,669,500	4,000,000	4,500,000	5,000,000	20,753,814



Past Scenario: HSCRC support at 50% match of Expenses

	2009	2010	2011	2012	2013	Total
Members	685,000	705,000	800,000	900,000	1,000,000	4,090,000
HSCRC	**1,927,927**	**1,834,750**	**2,000,000**	**2,250,000**	**2,500,000**	**10,512,677**
Grants & Donations	971387	1,129,750	1,200,000	1,350,000	1,500,000	6,151,137
Total	3,584,314	3,669,500	4,000,000	4,500,000	5,000,000	20,753,814



Attachments

Attachment A: MPSC Strategic Plan: Summary of Strategic Agenda aims from Charters

Strategic Agenda #1. Measure MPSC success on vision

Goal: The intent of Strategic Agenda #1 is to create state-wide accountability for safety within and across institutions, to track Maryland safety performance compared to other states, to demonstrate MPSC's impact through initiatives and programs, and to communicate that information through annual reports and meetings.

Strategic Agenda #2. Position Patient & Family Voices to Influence Safety

Goal: The intent of Strategic Agenda #2 is to engage patients and families in creating a safer healthcare system in Maryland. As consumers of healthcare, patients and families form the basis of the demand for quality healthcare services. MPSC's Patient and Family Voices strategy is designed to place patients and families as a compelling and effective driver of safety at the state and local institutional level.

Strategic Agenda #3. Demonstrate economic impact & value of safety

Goal: The intent of Strategy #3 is to demonstrate the value and economic impact of safety for patients and healthcare providers, as well as the value added by MPSC programs. MPSC recognizes that when an injury is avoided and quality is high, there are benefits, savings and efficiencies to the healthcare system and to patients. Strategy #3 also translates the call from legislators, regulars, and payers into a business case for the MPSC.

Strategic Agenda #4. Enable partner institutions to create & spread excellence

Goal: The intent of Strategic Agenda #4 is to identify safety excellence within institutions and to spread excellence across institutions and providers. MPSC is a recognized and valued convener in the Maryland healthcare community. As such, MPSC is able to bring individuals and organizations together to focus on common and critical issues that impact patient safety.

Strategic Agenda #5. Support institutions in developing cultures of safety that spread and maintain safety excellence

Goal: Strategy #5 will assist staff, Executives and Boards of healthcare institutions identify methods and approaches for creating cultures of safety. Leaders are integral to setting the tone

for safety within their organizations and for moving from a culture of blame to one of safety. MPSC recognizes the need to partner with leaders to support them to create a "burning platform" for safety. To accomplish this, MPSC will work directly with Boards and executives of healthcare organizations.

Strategic Agenda #6. Enable institutions to establish continuity of safe care across institutions

Goal: The intent of Strategy #6 is to have institutions working together to make patient transitions safe. MPSC will enhance programming for long term and home care providers. Representatives from across the continuum of care have been engaged as members of the Board of Directors, program advisory groups, and other meetings and opportunities offered by MPSC. MPSC will continue to build on this foundation to bring focus to the quality and safety hazards that occur as patients interact with multiple providers.

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[i] "The Eleventh Annual HealthGrades Hospital Quality in America Study." HealthGrades, Inc, October 2008. http://www.healthgrades.com/media/DMS/pdf/HealthGradesEleventhAnnualHospitalQualityStudy2008.pdf

[ii] Ibid.

HEALTH SERVICES COST REVIEW COMMISSION

NURSE SUPPORT PROGRAM II

FY 2010 COMPETITIVE INSTITUTIONAL GRANTS

STAFF RECOMMENDATIONS

May 13, 2009

These recommendations are presented for action by the Commission.

INTRODUCTION

This paper presents the Evaluation Committee and HSCRC staff recommendations for the FY 2010 Nurse Support Program II (NSP II) Competitive Institutional Grants.

BACKGROUND

At the May 4, 2005, HSCRC public meeting, the Commission unanimously approved funding of 0.1% of regulated patient revenue annually over the next ten years for use in expanding the pool of bedside nurses in the State by increasing the number of nurse graduates. The catalyst for this program was the finding that in fiscal year 2004, nearly 1,900 eligible nursing students were denied admission to Maryland nursing schools due to insufficient nursing faculty. In accordance with the Board of Nursing (BON) guidelines, nursing faculty are required to possess a Master's degree in nursing. The primary goal of the NSP II is to increase the number of bedside nurses in Maryland hospitals by expanding the capacity of Maryland nursing schools and, thereby, increasing the number of nurse graduates.

Following the approval of NSP II, the HSCRC assembled an advisory group of academicians, business leaders; and nurse executives. Together, this advisory panel held a series of meetings with the Maryland Association of Nurse Executives and the deans and directors of the State's nursing schools. In response to the issues expressed by these two groups, the advisory panel crafted two distinct but complementary programs to address the multi-faceted issues surrounding the nursing faculty shortage: 1) Competitive Institutional Grants, and 2) Statewide Initiatives. The HSCRC also contracted with the Maryland Higher Education Commission (MHEC) to administer the NSP II grants because of its expertise in the administration of grants and scholarships.

In 2006, the Governor introduced legislation to create a nonlapsing fund, the Nurse Support Assistance Fund, so that funds collected through hospital rates under NSP II can be carried forward to cover awards in future years and do not revert to the State's general fund at the end of the fiscal year. The legislation also provided that a portion of the Competitive Institutional Grants and Statewide Initiatives be used to attract and retain minorities to nursing and nurse faculty careers.

The Competitive Institutional Grants are designed to increase the structural capacity of Maryland nursing schools through shared resources, innovative educational designs, and streamlining the process to produce additional nurse faculty.

A. The types of initiatives that qualify for Competitive Intuitional Grants are as follows:

1) Initiatives to Expand Maryland's Nursing Capacity through Shared Resources
   - Develop the synergies between provider and educational institutions.

2) Initiatives to Increase Maryland's Nursing Faculty
   - Streamline the attainment of Master of Science in Nursing (MSN) degrees to increase nursing faculty.

3) Initiatives to Increase Nursing Student Retention
   - Provide tutorial support to decrease attrition and increase National Council Licensure Examination (NCLEX) pass rates.

4) Initiatives to Increase the Pipeline for Nursing Faculty
   - Provide incentives for nurses with either an Associate Degree in Nursing (ADN) or a Bachelor of Science in Nursing (BSN) to pursue an MSN thereby increasing the pool of qualified nursing faculty.

5) Initiatives to Increase Capacity Statewide
   - Provide support for innovative programs that have a statewide impact on the capacity to train nurses or nursing faculty.

The Competitive Institutional Grant process requires an Evaluation Committee to review, deliberate, and recommend programs for final approval by the HSCRC. The Statewide Initiatives are evaluated less formally and are awarded based on the qualifications and credentials of each applicant.

First and Second Rounds of NSP II Competitive Grants

During the first year, twenty-six proposals for the Competitive Institutional Grants were received by the March 7, 2006 due date. On April 12, 2006, HSCRC staff, following an Evaluation Committee process, recommended seven programs, including 21 educational institutions and hospitals, for funding, which was approved by the Commission (See Attachment II). MHEC staff conducted onsite visits to the organizations funded during the first year (FY 2007) of NSP II Competitive Institutional Grants and summarized findings in an annual report (www.hscrc.state.md.us).

For the FY 2008 NSP II Competitive Grants, twenty-three proposals were received by the due date of March 28, 2007. An Evaluation Committee, comprised of nursing administrators and educators recommended by the industry, a former Commissioner, and MHEC and HSCRC staff, reviewed all of the proposals based on the criteria set forth in the Request for Applications (RFA), the comparative expected outcomes of each initiative, the geographic distribution across the State, and the priority attached to attracting and retaining minorities in nursing and nursing faculty careers.

The Evaluation Committee unanimously agreed to recommend nine of the twenty-three proposals that were submitted for FY2008. These nine proposals included consortia representing 25 colleges and universities, health systems and hospitals. The programs addressed the multiple aspects of the nursing shortage by accelerating the number of ADN graduates, encouraging the pipeline of ADN to BSN students, and creating pathways to nursing faculty positions through accelerated MSN and doctoral programs.

Third Round of NSP II Competitive Grants

Four proposals were received for the FY 2009 NSP II Competitive Grant program by the due date of March 12, 2008. The Evaluation Committee recommended three of the four proposals. These three projects will bring a nursing program to a previously underserved county, will convert a doctoral nursing program to a hybrid distance learning format, and will bring graduate students into a certificate program in teaching nursing.

MHEC and the HSCRC staff took several steps to address the issues that may have contributed to the small number of proposals received last year for the NSP II Competitive Grant program. The deans and directors of the colleges and universities were surveyed to determine whether there are specific barriers, and many of their concerns were addressed. Additional technical assistance was provided last year to assist with proposal development. In addition, a survey was administered to solicit input on ways the program could be made more responsive and effective. Changes were made to the program as a result of this input, which led to many more proposal submissions for the fourth round.

Fourth Round of NSP II Competitive Grants

For FY 2010, twenty-eight proposals were received. The review panel for this round consisted of eight reviewers, six of whom were returning evaluators. This panel recommends the approval of twenty-one of the twenty-eight proposals, which would result in an additional expenditure of $20M over the next five years. These projects incorporate initiatives to increase capacity, improve retention, and add new technology for simulation and instruction. Two of the recommended proposals will provide statewide training in simulation for faculty and laboratory staff.

RECOMMENDATION

Commission Staff recommends the twenty-one Competitive Institutional Grants listed in Attachment I be approved by the Commission for FY 2010 in the funding amounts stated.

Nurse Support Program II --- Requests for FY 2010

#	Institution	Affiliates	Director	Project	Total	Projected Increase
NSP II 10-102	Allegany College	none	Fran Leibfreid	Creating a Smart Learning Environment to Retain Nursing Students	$ 131,639	66 graduates
NSP II 10-103	Allegany College	Anne Arundel CC	Fran Leibfreid	Enhancing Nursing Retention Through Tutoring	$ 600,000	70 graduates
NSP II 10-105	Bowie State Univ	none	Bonita Jenkins	Accelerated BSN w/ Retention and Success Initiative	$ 1,134,941	100 graduates
NSP II 10-106	Bowie State Univ	So. Md. Hospital & AAMC	Bonita Jenkins	Faculty Pipeline for RN to BSN & BSN to MSN	$ 588,317	70 graduates
NSP II 10-107	Carroll CC	none	Nancy Perry	Spring Start	$ 1,115,480	105 graduates
NSP II 10-108	Chesapeake CC	none	Judith Stetson	Model to Increase Graduation Rates of Nursing Students	$ 522,848	42 graduates
NSP II 10-109	College of Notre Dame	AAMC, HECC, Upper Chesapeake MC	Katharine Cook	Md. Partnership Project ot Increase Nursing Faculty	$ 888,537	50-60 graduates
NSP II 10-110	College of Southern Md.	none	Kathleen Lanigan	Southern Md. Nurse Retention Project	$ 903,398	36 graduates
NSP II 10-113	Frederick CC	none	Jane Garvin	Frederick CC ADN Support	$ 388,438	15 graduates
NSP II 10-114	Frostburg St. Univ.	none	Susan Coyle	Building the Nursing Faculty Pipeline in West. Md.	$ 265,845	40 graduates
NSP II 10-115	Hagerstown CC	none	Judith Oleks	Transforming Commty College Nursing Program Simulation Training in Md.	$ 1,330,000	n/a
NSP II 10-116	Harford Comm. Col	Upper Chesapeake Health	Laura Preston	Weekend & Evening Accelerated Nursing Program	$ 1,253,614	88 graduates
NSP II 10-117	Howard Comm. Col	none	Georgene Butler	Increasing Nursing Grads & Graduate Nurse Retention	$ 961,830	81 graduates
NSP II 10-118	Johns Hopkins Uni	Stevenson U, Howard CC, Montgomery CC, Bowie, Harford CC	Linda Rose	Establishing a Md. Faculty Academy for Sim. Teaching in Nursing Ed.	$ 618,936	n/a
NSP II 10-119	Johns Hopkins Uni	none	Kathleen White	Needs Based Grad Ed II-Online Masters Speciality	$ 1,644,793	208 faculty
NSP II 10-120	Montgomery CC	none	Barbara Nubile	Innovative Staffing	$ 1,795,639	85 graduates
NSP II 10-122	Morgan State Univ	none	Kathleen Galbraith	Addressing the Nursing & Fac. Shortage, Increasing Represntation of Minority Nurses	$ 1,123,638	151 graduates
NSP II 10-123	Prince George's CC	none	Cheryl Dover	RN Program Growth & Student Retention	$ 882,685	159 graduates
NSP II 10-124	Salisbury Universit	Peninsula RMC, Atlantic Gen Hospital	Lisa Seldomridge	Creation of New Dual Roles for Nurse Clinicians	$ 635,601	20 graduates
NSP II 10-127	Towson University	CCBC, Frederick Mem. Hosp., GBMC	Jacquelyn Jordan & Vicky Kent	Accelerated Associate to Master's Degree Program	$ 1,500,000	144 graduates
NSP II 10-128	UMB	BWMC, Good Sam., Mercy MC, Shore Health, Sinai Hos., Franklin Sq. HC	Dr. Mary Etta Mills	Master's Prep. of Staff Nurses to Expand Clinical Instr. Capacity	$ 1,948,041	100 graduates
	TOTAL				**$ 20,234,220**	1635

Attachment I

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, § 19-207 and 19-216, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .03** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on May 13, 2009, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendment will become effective on or about September 7, 2009.

Statement of Purpose

The purpose of this action is to require hospitals to file with the Commission its most recent Form 990 filed with the Internal Revenue Service in compliance with recently enacted legislation.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services

Cost Review Commission will consider comments on the proposed amendments until July 6, 2009. A hearing may be held at the discretion of the Commission.

.03 Reporting Requirements; Hospitals.

A.- L-3. Text Unchanged.

L-4. Internal Revenue Service Form 990. Beginning on October 1, 2009, each non-profit hospital shall submit its most recent Form 990 that the facility filed with the Internal Revenue Service within 30 days from the Internal Revenue Service filing.

M.- Q. Text Unchanged.

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207 and 19-214, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .03D** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on May 13, 2009, notice of which was given pursuant to State Government Article, §10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about September 7, 2009.

Statement of Purpose

The purpose of this action is to assure that the State's Medicare waiver is not jeopardized, and that any potential action taken by the Commission in response to the establishment of hospital day limits is in the public interest.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services

Cost Review Commission will consider comments on the proposed amendments until June 20, 2009. A hearing may be held at the discretion of the Commission.

.03 Regular Rate Applications.

A. – C. Text Unchanged

D. Uncompensated Care Policy – Medicaid Day Limits.

(1) – (2)(b) Text Unchanged.

(c) Any other financial considerations that are presented to the Commission with the partial rate application; [and]

(d) The hospital's position on the Commission's most recent Reasonableness of Charges analysis[.]**;**

(e) Whether changing a hospital's approved provision of uncompensated care in response to the establishment of hospital day limits places the Medicare waiver in potential jeopardy; and

(f) Whether implementing such a change to a hospital's approved provision of uncompensated care is in the public interest.

(3) – (5) Text Unchanged.

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §19-207, 19-214, 19-214.1, 19-214.2, and 19-214.3, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .26B(3), (4) and (5), and to add new regulations (6) and (7)** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on May 13, 2009, notice of which was given pursuant to State Government Article, §10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about September 7, 2009.

Statement of Purpose

The purpose of this action is to comply with recently enacted legislation. These Regulatory amendments change the interest or late payment charges that a hospital may add to its self-pay patients; set forth the minimum provisions required in hospital financial assistance policies; require hospitals to develop an information sheet; and set forth those requirements to be included in hospital credit and collection policies.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services

Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until July 6, 2009. A hearing may be held at the discretion of the Commission.

.26 Differentials

A. Text Unchanged.

B. Working Capital Differentials – Payment of Charges.

(1)-(2) Text Unchanged.

(3) A payer or self-paying patient, who does not provide current financing under § B(1)(a)-(e) of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers [and self-paying patients] not [generally] subject to the Insurance Article, **§ 15-1005,** Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(4) Hospital Billing Responsibilities.

(a)-(c)(ii) Text Unchanged.

(iii) [Patient] **Payers not subject to the Insurance Article, § 15-1005, Annotated Code of Maryland,** may be subject to interest or late payment charges at a rate of 1 percent per month beginning on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(5) Hospital Financial Assistance Responsibilities.

(a) On or before [April] **June** 1, 200[6]**9**, each hospital shall develop a written financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage. **The Financial Assistance Policy shall provide, at a minimum:**

(i) Free medically necessary care to patients with family income at or below 150% of the federal poverty level; and

(ii) Reduced-cost medically necessary care to low-income patients with family income above 150% of the federal poverty level, in accordance with the mission and service area of the hospital.

(b) A hospital whose current Financial Assistance Policy (i.e., as of May 8, 2009) provides for free or reduced-cost medical care to patients at income thresholds higher than the 150% level set forth above may not reduce that income threshold.

(c) [In addition, a] **A** notice shall be posted in conspicuous places throughout the hospital**, including the billing office,** describing the financial assistance policy and how to apply for free and reduced-cost care.

[b]**(d)** Each hospital shall use a Uniform Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost care.

[c]**(e)** Each hospital shall establish a mechanism to provide the Uniform Financial Assistant Application to patients who do not indicate public or private health care coverage.

(6) Hospital Information Sheet.

(a) Each hospital shall develop and information sheet that:

(i) Describes the hospital's financial assistance policy;

(ii) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(iii) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

1. The patient's hospital bill;

2. The patient's rights and obligations with regard to the hospital bill;

3. How to apply for free and reduced-cost care; and

4. How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;

(iv) Provides contact information for the Maryland Medical

Assistance Program; and

(v) Includes a statement that physician charges are not included in the hospital bill and are billed separately.

(b) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(i) Before discharge;

(ii) With the hospital bill; and

(iii) On request.

(c) The hospital bill shall include a reference to the information sheet.

(d) The Commission shall:

(i) Establish uniform requirements for the information sheet; and

(ii) Review each hospital's implementation of and compliance with the requirements of this subsection.

(7) Hospital Credit and Collection Policies.

(a) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients.

(b) The policy shall:

(i) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(ii) Prohibit the hospital from selling any debt;

(iii) Prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained;

(iv) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(v) Describe the hospital's procedures for collecting and debt; and

(vi) Describe the circumstances in which the hospital will seek a judgment against a patient.

(c) The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of subsection (b) of this section.

C. Text Unchanged.

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

HEALTH SERVICES COST REVIEW COMMISSION
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FAX 410-358-6217
Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

TO: **Commissioners**

FROM: **Legal Department**

DATE: **May 8, 2009**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

June 3, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
July 1, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**

Please note, Commissioner packets will be available in Commission offices at 8:30 a.m.

The agenda for the Executive and Public Sessions will be available for your review on the Commission's Web Site, on the Monday before the Commission Meeting. To review the agenda, visit the Commission's web site at http://www.hscrc.state.md.us