457th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
EXECUTIVE SESSION

******* Cancelled *******

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION

June 3, 2009
9:00 a.m.

1. Review of the Public Minutes of May 13, 2009

2. Executive Director's Report

3. Docket Status - Cases Closed

2009A - University of Maryland Medical Center
2022R - Civista Medical Center
2023A - University of Maryland Medical Center

4. Docket Status - Cases Open

2021R - Johns Hopkins Bayview Medical Center
2025N - Johns Hopkins Hospital
2026N - The Edward W. McCready Memorial Hospital
2027R - Good Samaritan Hospital
2028A - University of Maryland Medical Center
2029A - Holy Cross Hospital

5. Final Recommendations regarding HSCRC Payment Policy for Highly Preventable Hospital Acquired Conditions

6. Final Recommendations on Maryland Patient Safety Center Funding for FY 2010

7. Draft Recommendations for Revisions to the Charge Per Visit Methodology

8. Draft Recommendations regarding Case-mix and the Case-mix Governor

9. Briefing on Achieved and Expected Outcomes of the Nurse Support Program II

10. Maryland Hospital Community Benefits Report Summary and Update

11. Legal Report

12. Hearing and Meeting Schedule

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

AS OF MAY 21 , 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
2021R	Johns Hopkins Bayview Medical Center	3/6/09	6/3/09	8/4/09	CAPITAL	GS	OPEN
2025N	Johns Hopkins Hospital	4/16/09	6/3/09	9/14/09	AUD	CO	OPEN
2026N	The Edward W. McCready Memorial Hospital	4/27/09	6/26/09	9/24/09	RDL	CO	OPEN
2027R	Good Samaritan Hospital	5/1/09	6/30/09	9/28/09	ICU/CCU	CO	OPEN
2028A	University of Maryland Medical Center	5/12/09	N/A	N/A	ARM	DNP	OPEN
2029A	Holy Cross Hospital	5/19/09	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

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**

* *

Staff Recommendation

June 3, 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 $7.03 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 $7.03 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.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
McCREADY MEMORIAL	*	**DOCKET:**	**2009**
HOSPITAL	*	**FOLIO:**	**1836**
CRISFIELD, MARYLAND	*	**PROCEEDING:**	**2026N**

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Staff Recommendation

June 3, 2009

Introduction

On April 20, 2009, McCready Memorial Hospital (the "Hospital") submitted a partial rate application to the Commission requesting a rebundled rate for Renal Dialysis (RDL). The Hospital is requesting that the statewide median rate be approved for the Hospital effective June 1, 2009.

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 a new service be waived;
2. That the RDL rate of $637.53 per treatment be approved as a rebundled rate effective June 1, 2009;
3. That no adjustment be made to the Hospital's current charge per case standard for RDL;
4. That the RDL rate not be rate realigned until a full year's cost experience has been reported to the Commission.

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
GOOD SAMARITAN	*	DOCKET: 2009
HOSPITAL	*	FOLIO: 1837
BALTIMORE, MARYLAND	*	PROCEEDING: 2027R

* *

Staff Recommendation

JUNE 3, 2009

Introduction

On April 29, 2009, Good Samaritan Hospital (the "Hospital") submitted a partial rate application to the Commission requesting its Medical Intensive Care Unit (MIS) and Coronary Care Unit (CCU) approved rates be combined effective July 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 MIS 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	$3,133.42	933	$2,923,482
Coronary Care	2,269.92	1,527	3,466,165
Combined Rate	2,597.42	2,460	6,389,647

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 July 1, 2009.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
HOLY CROSS HOSPITAL	*	**DOCKET:**	**2009**
	*	**FOLIO:**	**1839**
SILVER SPRING, MARYLAND	*	**PROCEEDING:**	**2029A**

*** ***

Staff Recommendation

June 3, 2009

Introduction

On May 18, 2009, Holy Cross Hospital (Holy Cross or the Hospital) requested that the Commission approve its continued participation in the alternative method of rate determination (ARM) arrangement with the Kaiser Health Plan of the Mid-Atlantic States, Inc. (Kaiser).

This arrangement was first approved as a Demonstration Project, approved July 1, 2005 for two years and was extended for two additional years at the Commission's July 18, 2007 public meeting. Under the arrangement, Holy Cross was grants a reduction in rates of 3.15% to Kaiser members to reflect three discrete activities by Kaiser that generate cost savings to Holy Cross. The activities are: 1) the reduction of Kaiser's retroactive denials, valued at 0.53%; 2) the provision of case managers, valued at 1.25%; and 3) the elimination of collection costs and the immediate access to payment, valued at 1.37%.

In addition, to the rate reduction, the Commission permitted Kaiser to utilize its greater purchasing power to reduce the cost of major medical devices (surgically implanted vender-delivered devices costing a minimum of $2,500) for its members at Holy Cross. The rationale for the Commission's approval was that: 1) Holy Cross would reduce its CPC target by the invoice cost it would have paid for the devices if it had purchased them; 2) this would reduce the Hospital's total allowable revenue; and 3) since the System is capped, the amount of revenue removed from the Hospital's allowable revenue would be available to other hospitals.

Holy Cross has requested that the Demonstration Project be allowed to continue indefinitely.

Findings

As a condition for continued approval, Holy Cross was required to provide a letter of

attestation, 30 days after the end of its fiscal year, that the activities of Kaiser continued to justify the 3.15% discount approved by the Commission. The fiscal 2007 attestation letter indicated that the savings associated with Kaiser's three cost cutting activities produced savings of 3.08%, and the fiscal 2008 letter indicated savings of 3.26% (an average of 3.18% over the two year period).

In addition, in accordance with the terms of the arrangement, Holy Cross' total allowed revenue for FY 2008 was reduced by $954,443, which is equal to the cost of the medical devices not provided by Holy Cross to Kaiser's patients.

Staff Recommendation

The Demonstration Project shows that the cost cutting activities of Kaiser continue to justify the discount approved by the Commission, and that Kaiser's provision of medical devices has produced Savings to the system. Therefore, staff recommends:

1) that the Demonstration Project be continued for an additional two years, beginning July 1, 2009;

2) that 30 days after the end of its fiscal year the Hospital provide a letter of attestation that Kaiser's three cost savings activities continue to justify the 3.15% discount;

3) that in regard to the provision of major medical devices by Kaiser for its members, the Hospital provide the data as prescribed by staff in the letter from Dennis N. Phelps to Gary Vogan dated June 15, 2005, attached; and

4) that the Hospital be required to apply for continuation of this arrangement beyond June 30, 2011.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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June 15, 2005

Gary E. Vogan, Chief Financial Officer
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, Maryland 20910

Dear Mr. Vogan:

At its June 1, 2005 public meeting, the Health Services Cost Review Commission (the Commission) approved the alternative method of rate determination application of Holy Cross Hospital (HCH) to enter into an arrangement with Kaiser Health Plan of the Mid-Atlantic States, Inc. (Kaiser). Effective July 1, 2005, this arrangement grants a reduction in rates of 3.15% to Kaiser members to reflect three cost saving activities. These are: 1) the reduction of Kaiser's retroactive denials; 2) provision of case managers; and 3) elimination of collection costs and immediate access to payment. In addition, because of Kaiser's greater purchasing power, the Commission granted Kaiser permission to provide major medical devices, i.e., surgically implanted vender-delivered devices costing a minimum of $2,500, for its members at HCH.

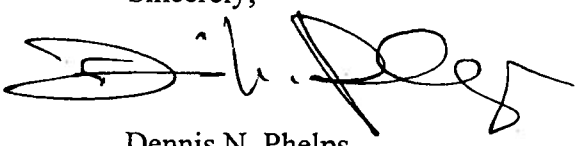
The purpose of this letter is to detail HCH's reporting requirements associated with the arrangement. With respect to the aforementioned three cost cutting activities, HCH must provide a letter of attestation that Kaiser continues to justify the discounts approved by the Commission thirty days after the end of its fiscal year.

In regard to the provision of major medical devices by Kaiser for its members, HCH must: 1) provide, 30 days after the end of each calendar quarter, a list of the cases by patient account number, with the invoice cost of the major medical device billed to Kaiser, as well as the total charges for the case; 2)"flag" the cases for which Kaiser provided the devices on its quarterly discharge data abstract tapes as follows - - - Record Type 1, Position 242, identify with letter "K"; and 3) ensure that Kaiser provides annually to the Commission, by October 1st, the number of major medical devices provided for its members at HCH and the actual aggregate invoice

costs of the devices.

If you have any questions concerning the above, you may contact me at 410-764-2565.

Sincerely,



Dennis N. Phelps
Associate Director,
Audit & Compliance

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

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(410) 764-2605
Fax (410) 358-6217
June 3, 2009

This document represents the final approved recommendations presented to the Commission at the June, 3, 2009 meeting. These recommendations were approved as written with the added requirement that HSCRC staff provide updates to the Commission on the input and results of the June 2009 Potentially Preventable Complication (PPC)/MHAC clinical vetting session at the July 1, 2009, and of the July 2009 clinical vetting session at the August 2009 Commission meeting. The results presented to the Commission must include any changes made to the PPCs/MHACs based on the feedback from the vetting sessions.

Background

In March 2009 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

Through March and April of 2009, HSCRC staff 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.

Another technical subgroup met on May 13th, 2009 to determine the layout and content of hospital specific MHAC/PPC reports. The meeting included 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 participated in a statewide technical meeting that HSCRC convened on May 19, 2009 to review methodology and the calculations so hospitals are able to replicate their own MHAC/PPC rate calculations. 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.

Appendix E provides a list and timeline of past and planned future efforts to provide reports on the PPCs to hospitals, to vet the technical and clinical components of the PPCs, and to provide and receive relevant critical feedback as we plan and embark upon implementation.

Comments on the draft recommendation were requested by May 27, 2009; two letters were received and are included with this document following Appendix E. HSCRC staff would address the concerns raised as follows:

- HSCRC will consider the clinical issues raised in the letters in the two clinical vetting sessions as outlined in the timeline in Appendix E.
- Regarding the concern that case reports have not been distributed to hospitals, hospitals have received their case reports the week of May 25, 2009.
- Regarding the concern about hospital POA data for three facilities, as of the first quarter of FY 2009, only one hospital has not complied with the requirements for valid POA data, and staff will work with this hospital, applying fines if needed, to bring the data into compliance.

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.

Final Recommendations

1) Implement the proposed rate-based methodology that compares actual hospital performance to a normative expected standard of potentially preventable complications (PPCs) on a risk-adjusted basis using APR-DRGs;[1]

2) Use of 52 Potentially Preventable Complications (out of a total of 64 PPCs) that were found to yield a statistically significant result in the regression analysis performed to estimate the marginal hospital charge increase associated with the presence of a PPC;[2]

3) Use the proposed indexing method for calibrating and ranking relative hospital performance as illustrated in Appendix D (table 4) which compares the dollar impact of a presence (or absence of a PPC – relative to the normative expected standard) relative to a hospital's "at-risk" inpatient revenue;[3]

4) Implement this methodology effective July 1, 2009 through June 30, 2010 (FY 2010 measurement year);

5) Use normative expected standards as calculated from experience during FY 2009;[4]

6) Apply rewards and penalties to the update factor per a scaling methodology (subject to further discussion and review) on a revenue neutral basis beginning FY 2011; and,

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[1] Note: Potentially Preventable Complications are a product of 3M Health Information Systems.

[2] Note: the recommendation is also to drop PPC 63 for the same reasons cited in the original March 4, 2009 MHAC recommendation adopted by the Commission.

[3] Note: "At-risk" revenue reflects revenue after global exclusions.

[4] Note: Hospitals have been given available data through December 2008 and will receive subsequent quarters to enable them to keep track of expected rates on an on-going basis. Final expected values will be provided to hospitals when final case-mix data are submitted, likely in October 2009.

7) 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.

Other Recommendations and Important Considerations

8) Collapse the performance of Johns Hopkins Oncology into the performance of the overall hospital for index measurement and scaling considerations (consistent with the handling of oncology units of other hospitals).

9) Staff is further recommending allowing a period for additional input and suggested changes to the PPC exclusion logic through July 15, 2009.

10) It is further recommended that comments and input regarding the HSCRC's MHACs and PPCs received after July 15 be accumulated and considered for future (FY 2011) refinements of the MHAC methodology (although staff will be receptive to examining any concerns raised that it believes may substantially threaten the efficacy of the MHAC methodology during the course of FY 2010 and thereafter).

11) A technical issues/payment workgroup will be assembled in June 2009 to begin to identify and consider payment-related issues – such as the most appropriate scaling methodology, the most appropriate magnitude of revenue to put at risk for the application of rewards and penalties based on relative hospital performance and other issues raised.

12) Other completed and planned activity and discussions include (Appendix E):

    - Technical conference on data and reporting considerations- in May;
    - HSCRC convening an initial clinical input session – in June; and
    - HSCRC convening a final clinical input session – in early July.

13) In future years, staff recommends inclusion and/or exclusion of PPCs from the approved list of PPCs used in the HSCRC's MHAC methodology based on the yield (or failure to yield) of a statistically significant result in the regression analysis performed to estimate the marginal hospital charge increase associated with the presence of a PPC over two consecutive years.

14) Staff is finalizing an arrangement with St. Paul Computer Center and 3M for the availability of a tracking tool to enable hospitals to track performance vis-a-vis an estimated/actual normative expected standard.

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 Infectior	$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	0.89060	-$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%	$4,865,205	-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	96	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	Pennisula 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	$258,878		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	Pennisula 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	$116,443
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	2,688		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	11,248	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	Pennisula 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	8.8
	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	-$69,878
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			*$5,843*			*$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	Pennisula 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	Pennisula 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	592	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	11,136	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	6,676	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	$19,387		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	Pennisula 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	$68,608		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	11,188	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	4,656	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	Pennisula 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	Pennisula 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

Provider	Row	Hospital	PPC 29 $1,415 Number of Cases At Risk	PPC 29 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 29 Row A: Expected Number of Cases Assigned PPC / Row B: Resource Use/Savings	PPC 31 $18,231 Number of Cases At Risk	PPC 31 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 31 Row A: Expected Number of Cases Assigned PPC / Row B: Resource Use/Savings	PPC 32 $48,575 Number of Cases At Risk	PPC 32 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 32 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	Pennisula 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	Pennisula 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		0.56	$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			6.08	$22,075		0.97	$15,304		0.60	$18,525
		Total	405,361	734		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	Pennisula 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	$66,672		-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	6.3	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			-4.06	-$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	Pennisula 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

			PPC 50			PPC 51			PPC 52		
			$14,138			*$20,608*			*$8,776*		
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	13,821	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	Pennisula 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	11,606	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		520,748	234		514,872	962	

Appendix C
Table 3: Detailed Provider Rates by PPC

Provider	Row	Hospital	PPC 53 $15,073 Number of Cases At Risk	PPC 53 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 53 Row A: Expected Number of Cases Assigned PPC / Row B: Resource Use/Savings	PPC 54 $22,295 Number of Cases At Risk	PPC 54 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 54 Row A: Expected Number of Cases Assigned PPC / Row B: Resource Use/Savings	PPC 56 $2,137 Number of Cases At Risk	PPC 56 Row A: Actual Number of Cases Assigned PPC / Row B: Case Differential	PPC 56 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	3,166	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	5,875	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	Pennisula 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	1,164	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

Appendix E

MHAC/PPC Implementation: Key Activities and Timeline

Distribution of data/reports to hospitals:

May 22, 2009 – HSCRC staff will send out the following data/reports to the hospital case-mix liaisons:

- Excel file with PPC detail for all FY08 inpatient cases
- PDF reports for cases that have a PPC for FY08 inpatient data

Early June, 2009 – HSCRC staff will send out the following data/reports to the hospital case-mix liaisons:

- Appendix C, Table 3 of PPC Recommendation – 'Detailed Provider Rates by PPC' using FY09 Q1 & Q2 data (July – Dec, 2008). **The statewide standard rate and PPC regression values will be based on FY08 data.**
- Excel file with FY09 Q1 & Q2 PPC detail for all inpatient cases
- PDF reports for cases that have a PPCs for the FY09 Q1 & Q2 data period

Late July, 2009 – HSCRC staff will send out the following data/reports to the hospital case-mix liaisons:

- Appendix C, Table 3 of PPC Recommendation – 'Detailed Provider Rates by PPC' using FY09 Q1-Q3 data (July 2008 – March 2009). **The statewide standard rate and PPC regression values will be based on FY08 data.**
- Excel file with FY09 Q3 (only) PPC detail for all inpatient cases
- PDF reports for cases that have a PPCs for the FY09 Q3 (only) data period

Late October, 2009 – HSCRC staff will send out the following data/reports to the hospital case-mix liaisons:

- Appendix C, Table 3 of PPC Recommendation – 'Detailed Provider Rates by PPC' using FY09 data (July 2008 – June 2009). **The statewide standard rate and PPC regression values will now be based on FY09 data using the October 2009 release of the PPC software.**
- Excel file with FY09 Q4 (only) PPC detail for all inpatient cases
- PDF reports for cases that have a PPCs for the FY09 Q4 (only) data period

Schedule of PPC Clinical Vetting Sessions (to incorporate changes into the PPC software to be released October 1, 2009):

- May 25, 2009 – June 30, 2009 – Period for industry to comment on PPCs based on review of FY08 data. Comments to be provided during vetting sessions or submitted via Commission website.
- Mid/late June 2009 – HSCRC staff will convene a statewide clinical feedback session on PPCs
- Late June/Early July 2009 - HSCRC staff will review and categorize feedback and comments
- Early July 2009 - PPC Vetting session related to industry comments led by 3M clinical staff
- Mid July 2009 - Industry vetted PPC revisions finalized

Maryland
Hospital Association

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May 26, 2009

Dr. Donald Young
Chairman, HSCRC
6109 Trotter Ridge Court
Columbia, MD 21044

Dear Dr. Young: Don

As a follow-up to the May 13 Commission meeting, I am writing to provide the Maryland Hospital Association's comments and recommendations on the *Revised Draft Staff Recommendations Regarding HSCRC Payment Policy for Highly Preventable Hospital Acquired Conditions.* You will be asked to take action on this new policy at your June 3 meeting. **Maryland will become the first state in the nation to link payment to this methodology.** The new proposal is a significant improvement over the previous staff proposal. We recommend that you vote in favor of its adoption with the following important changes:

- Implement a clinical review process to refine and narrow the potentially preventable complications (PPCs) prior to implementation of this policy;
- Start with a modest amount of money at risk;
- Use corridors when scaling payment adjustments; and
- Do not penalize hospitals twice for the same case.

Following is a more detailed explanation of each recommendation.

Recommendation 1: The new policy greatly expands the number of conditions included from 11 to 52 PPCs. Between now and July 15, the HSCRC should lead a process with hospitals and clinicians, with a published timeline for meetings, to examine the PPCs from a clinical perspective and refine and narrow the number included, based on the PPC's inclusion into the following four categories:

1. PPC is clinically appropriate and relevant to include in the 2009 policy;
2. PPC use requires revisions to existing inclusion conditions/codes;
3. PPC use requires revisions to existing exclusion conditions/codes; and
4. PPC does not meet clinical appropriateness or relevance and should be removed from the 2009 policy.

The following criteria should be used to determine the disposition of each PPC:

- Are there clinical issues that necessitate amendments to the inclusions or exclusions within a PPC or elimination of an entire PPC?

- Has the condition been accepted or rejected by a nationally recognized agency or organization such as the Centers for Medicare and Medicaid Services or the National Quality Forum? If so, for what reason?

- Are the conditions or codes represented in the PPC overly broad or too ambiguous?

A few early-identified examples of PPCs that should be revised or excluded from the HSCRC's payment policy illustrate the need for this review:

- PPC 64 – Other In-Hospital Events includes too diverse a group of conditions. This PPC includes patients who have a diagnosis code for rape, suicide and assault—all serious, egregious events—but also includes patients who have a diagnosis code for a fall. The definition of a fall may be very different between hospitals and does not necessarily indicate injury to the patient. This PPC has too broad a clinical scope, and it may be more appropriate to include just the egregious events of rape, suicide and assault. PPC 28 – In-Hospital Trauma and Fractures will appropriately identify patients who sustain an injury from a fall.

- PPC 31 – Pressure Ulcers includes patients who develop a pressure ulcer of any stage in the hospital (Stage 1 through 4, where Stage 1 is redness on the skin that does not disappear with pressure and Stage 4 is a full-thickness ulcer extending to the bone or muscle). CMS has a Hospital-Acquired Condition (HAC) for Pressure Ulcers, but includes only Stage 3 and 4 pressure ulcers. The National Quality Forum also includes only Stage 3 and 4 pressure ulcers in its list of Never Events due to the clinical significance of these stages.

- PPC 52 – Inflammation and Other Complications of Devices, Implants or Grafts Except Vascular Infection includes patients with a diagnosis code that includes one of the following reactions due to specific devices or implants: infection causing obstruction, inflammation reaction, fibrosis, stenosis, embolism, pain or any other unspecified complication due to the device. This list is very broad—from pain to infection—and the less severe reactions may, in fact, not result in any increased utilization of hospital resources. This PPC also does not have a specific exclusion for patients admitted with an existing infection, which could place them at increased risk for developing an inflammatory response or infection from a necessary device or implant placed during the hospital stay.

- PPC 36 – Acute Mental Health Changes includes patients who develop conditions such as hallucinations, presenile delirium or delusions, and dementia with behavior disturbance while in the hospital. CMS rejected a similar HAC due to difficulty in

accurately diagnosing these very specific types of mental health disorders and difficulty in accurately determining their presence on admission. Some patients with these types of mental health disorders may exhibit these symptoms only under certain circumstances or certain times of day, rendering conclusive diagnosis difficult during the inpatient hospital stay.

Further, 3M and HSCRC staff are currently in the process of preparing reports for hospitals, identifying the cases affected by this new proposal using FY 2008 data. Just as was done when the original Maryland Hospital-Acquired Conditions (MHAC) policy was proposed, it is important to give hospitals the opportunity to review cases with the additional PPCs and have questions and concerns resolved. Data are being provided to hospitals using this new methodology for the first time on May 26. As you will recall, under the original proposal this resulted in the elimination of some PPCs and additional exclusions for others.

Recommendation 2: Initiate this new payment policy with a modest amount of money at risk in the early years.

The new rate-based methodology is a significant improvement over the previous case-specific approach. We appreciate the effort that was undertaken to respond to the concerns with the original MHAC payment policy raised by hospitals and physicians. However, it is still an untested method, and this is the first time that the 3M product would be linked to payment anywhere in America. Proceeding in a fiscally responsible manner is prudent.

Recommendation 3: The scaling of hospital payment adjustments should be done using corridors, rather than on a continuous process.

The proposed hospital payment logic "scales" a portion of the update factor based on relative hospital positions determined by the presence or absence of MHACs. Application of continuous scaling assumes high precision in the MHAC methodology which is not the case. The HSCRC should consider using corridors for payment adjustments, similar to the existing update factor scaling policy. The HSCRC's FY 2010 Update Factor scaling policy resulted in adjustments to hospitals with Reasonableness of Charges (ROC) positions below the 25th percentile and above the 75th percentile, with the larger adjustments applied below the 10th percentile and above the 90th percentile. A similar methodology may be applied to the MHAC payment logic, creating an acceptable range of scores around the statewide average that result in no penalties or rewards.

Recommendation 4: In those instances in which hospitals' payments are already adjusted under other reimbursement methodologies, the HSCRC should not impose a second payment adjustment (i.e., no double-payment penalties).

While the application of a relative payment scale alleviates the previous case-specific payment decrements, there are still concerns related to overlapping payment adjustments. First, as in the previously approved methodology, any case "written off" in its entirety as a contractual

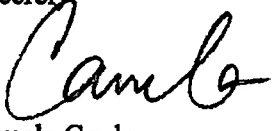
allowance (subject to audit), should not be counted against a hospital. A hospital has already incurred a financial penalty by foregoing the revenue associated with that particular case, and, should not be subjected to further penalty.

Second, to the extent MHAC policy drives changes in a hospital's case-mix index (CMI) based on underlying severity of illness or APRDRG assignment changes, these CMI changes should be considered if a hospital is subject to a CMI governor. The proposed MHAC payment logic will reduce overall hospital payments if a hospital exceeds the statewide average for all MHACs. As this correlates with underlying CMI changes, a hospital subject to CMI governor should not be penalized further.

Finally, staff should evaluate further the overlap of cases with the presence of one or more MHACs that result in outlier (trimmed) revenue. In many cases, the presence of an MHAC may cause a hospital to exceed its charge-per-case revenue authority by a substantial amount up to the trim point. This "dead zone" loss already reduces a hospital's charging authority, possibly exceeding the value of the MHAC Severity of Illness/APRDRG assignment increase. The proposed payment adjustments are determined by relative hospital positions. Relative hospital positions should be adjusted for these types of financial reductions that have already been applied to each circumstance.

Thank you for the opportunity to provide these comments. If you need additional information, I can be reached at 410-379-6200 or ccoyle@mhaonline.org.

Sincerely,



Carmela Coyle
President and CEO

cc: Robert Murray, Executive Director, HSCRC

WASHINGTON COUNTY
HEALTH SYSTEM

Raymond A. Grahe
Vice President for Financial Services

Washington County Health System
251 East Antietam Street
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May 20, 2009

Robert Murray, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: HSCRC Payment Policy for Highly Preventable Hospital Acquired Conditions

Dear Bob:

Thank you for the opportunity to comment on the staff recommendation regarding the payment policy for the highly preventable hospital acquired conditions. We have identified the following issues as areas of concern regarding this proposed policy.

1. This policy uses predictive modeling to compare a hospital's actual incidence of potentially preventable complications (PPCs) with the expected statewide incidence. This modeling is based on the acceptable coding of present on admission (POA). As stated in the staff recommendation, there are 3 hospitals that are still not submitting acceptable POA coding. Coding for POA is a new requirement; therefore, there is a learning curve associated with the quality of POA coding being submitted by the 43 hospitals currently reporting. This learning curve could potentially skew the integrity of the data being used in the predictive modeling for this payment policy.

2. There has been no clinical validation of this payment policy. As we understand it, this policy was designed to provide incentives encouraging hospitals to focus on sustained quality improvement. If quality improvement is the overriding goal, should there not be clinical validation of the policy to insure the goal is met?

3. To date, hospitals have been unable to obtain the case specific data used in the calculation of the FY08 impact analysis. The absence of this detailed data has greatly diminished our ability to analyze and understand our PPC ranking. It is critical that hospitals have access to this case specific data on a real-time basis in order to analyze and react to "problem" PPCs. We need the ability to provide specific examples to our medical staff to address potential documentation deficiencies that impact the POA coding and subsequently impact our PPC results.

In conclusion, we appreciate the HSCRC's commitment to improve the quality of care rendered in Maryland hospitals. Thank you for your consideration of our concerns. We look forward to hearing back from you regarding these issues. Please contact me at 301-790-8102 should you need any additional information.

Sincerely,

Raymond A. Grahe
Vice President for Financial Services

cc: Dr. T. Michael White, WCHA
Dianna Rounds, WCHA
Patti Markunas, WCHA
Jocelia Rotz, WCHA

WASHINGTON COUNTY HOSPITAL

Washington County Hospital
251 East Antietam Street
Hagerstown, MD 21740
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Health Care Cost Review Commission
Wednesday, June 3, 2009

Clinical Presentation:

1. >1500 cases to review (i.e., chaos).
2. To make sense of chaos, as our laboratory, we chose to study cases from our award-winning joint program.
3. In the time allowed, we studied 8 cases (~0.5%).
4. For clarity, I will confine my comments to a subset of four straight-forward; readily understood cases:
   - Each patient presented for elective joint replacement.
   - To prevent wound infection, each had a peri-operative urinary catheter which was by protocol removed on the 2nd hospital day.
   - Per protocol, each had a urinalysis and urine culture on the 3rd day.
   - Each patient was asymptomatic.
   - Each urinalysis was normal.
   - Each urine culture was positive.
   - Each patient received a short course of antibiotics to sterilize the urine.
   - Each was coded with a secondary diagnosis of urinary tract infection.
   - Each was identified as a MD HAC/PPC.
5. Here are our clinical takeaways:
   - Use of the Foley catheter is the right thing to do (to prevent devastating wound infection).
   - Culturing all urines on admission to prove "present on admission" would be the wrong thing to do (although we know many of these patients would grow an organism on admission, this would be an abuse of lab services and resource utilization).
   - We should recognize "asymptomatic bacteruria" as the condition and not diagnose "urinary tract infection".
   - Physicians need new terminology [asymptomatic bacteruria vs. urinary tract infection]; and, coders need a new code [791.9 vs. 599.0].
   - A brief course of antibiotics is the right thing to do.
   - "Asymptomatic bacteruria" would not be recognized as a MDHAC/PPC.
   - After review (40 hours), documentation and coding may change but care will not.

T. Michael White, MD FACP
Chief Medical Officer
Washington County Hospital

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

June 3, 2009

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

This Recommendation was approved by the Commission on June 3, 2009

Final 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. To date, the Collaborative has resulted in 88 babies that were provided specialty care but were not treated in the NICU or were treated with a lower level of care resulting in an estimated reduction in the cost of care by $87,000 to $185,000. In addition, for each baby not requiring specialty care in a NICU or intermediate care, the savings would be approximately $10,000.

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

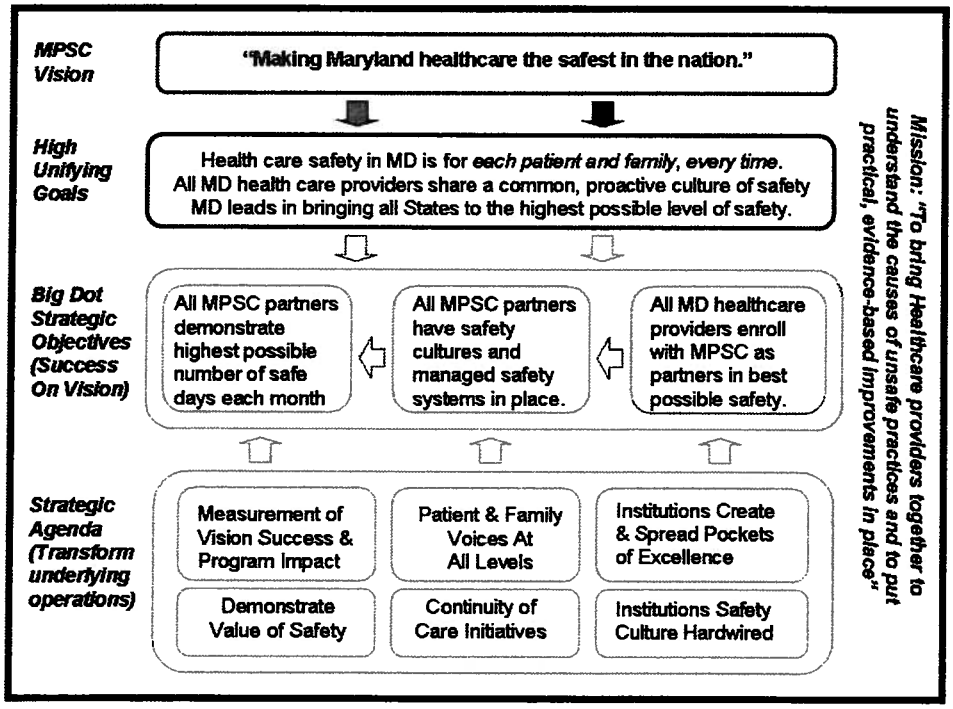
Through a participatory planning process, the MPSC engaged its Board of Directors, external stakeholders and partners, healthcare community representatives, and staff to contribute to the strategic plan of the Center. MPSC staff interviewed each Board member, gaining many rich insights that resulted 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

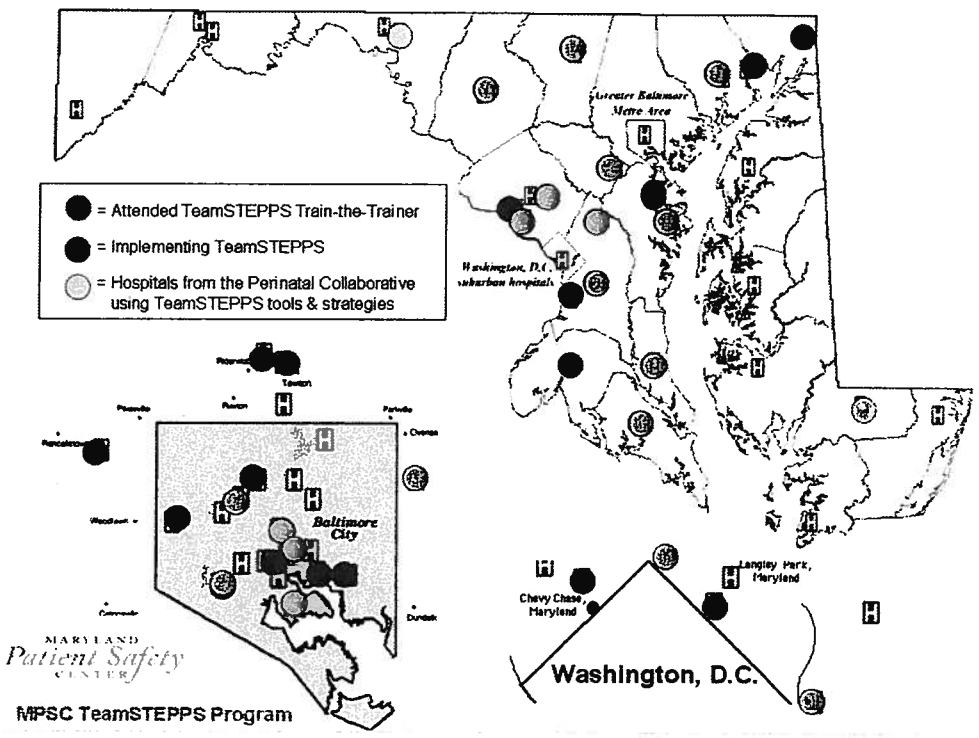
MPSC's Methicillin resistant Staphylococcus aureus (MRSA) initiative began more than two years as a pilot project. Two Maryland hospitals were part of a Robert Wood Johnson grant using a change approach called Positive Deviance (PD) based on the discovery of innovations at the grass roots level. In applying 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:

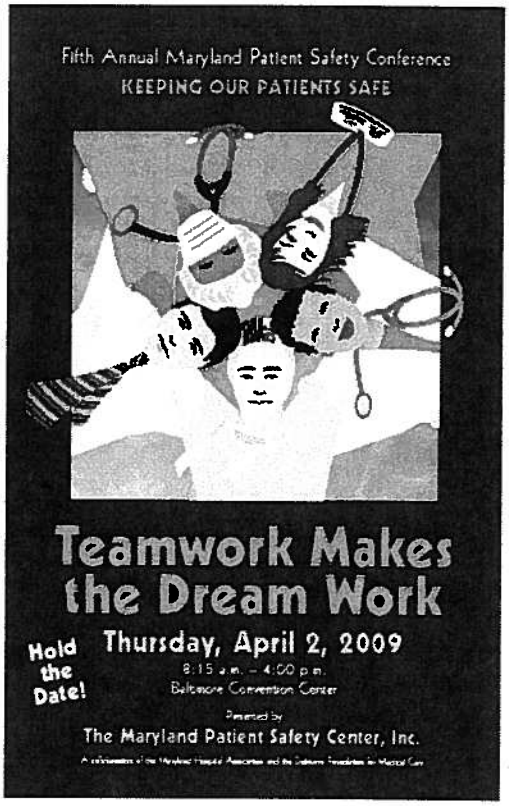
- Specific tools to address potential conflicts between accountability and just cultures.
- Reinforce skills for leaders to use in engaging patients and families.
- How do we advance innovation? How do we sustain improvement? The answer to those questions is vital to patient safety improvement.

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.

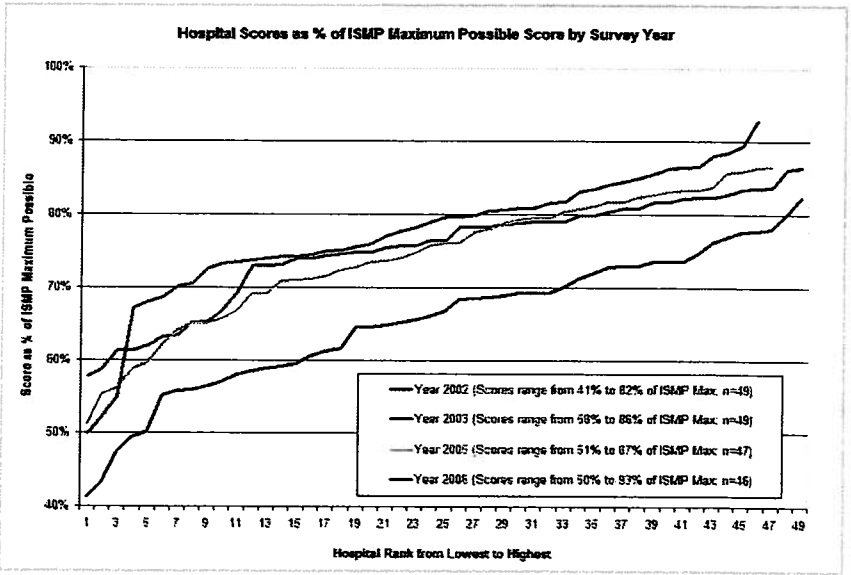
Research Programs

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.

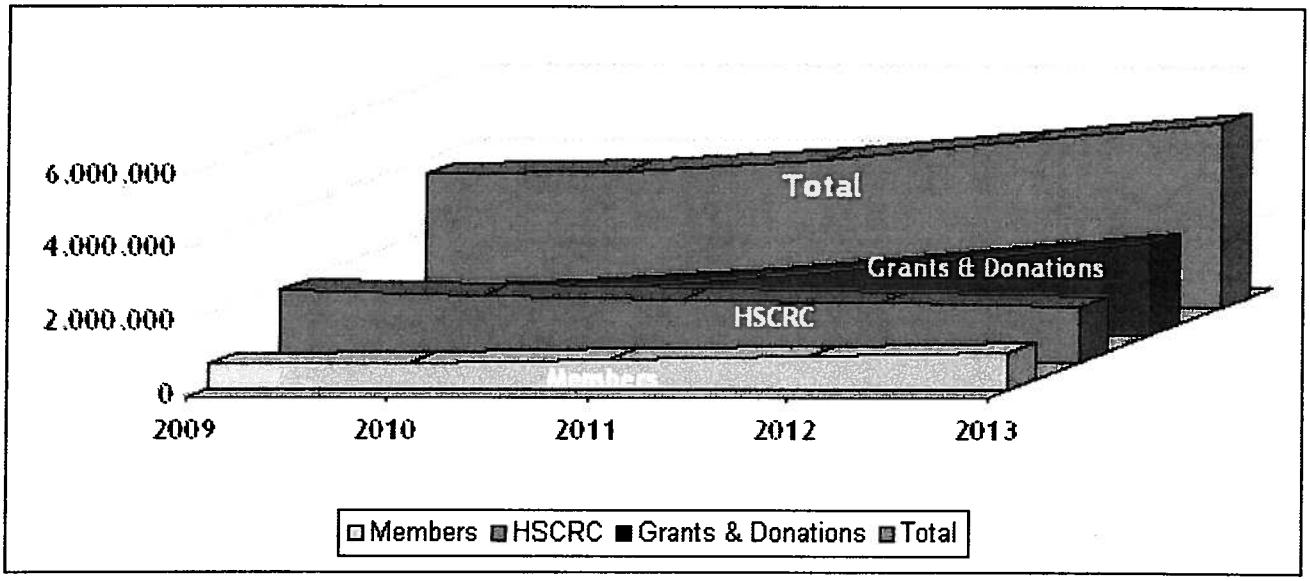
The budget shortfall ($428,575) represents the minimum of the required funding that MPSC will raise as part of the *MPSC Keeping Patients Safe Campaign*

Funding Projections/Scenarios

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

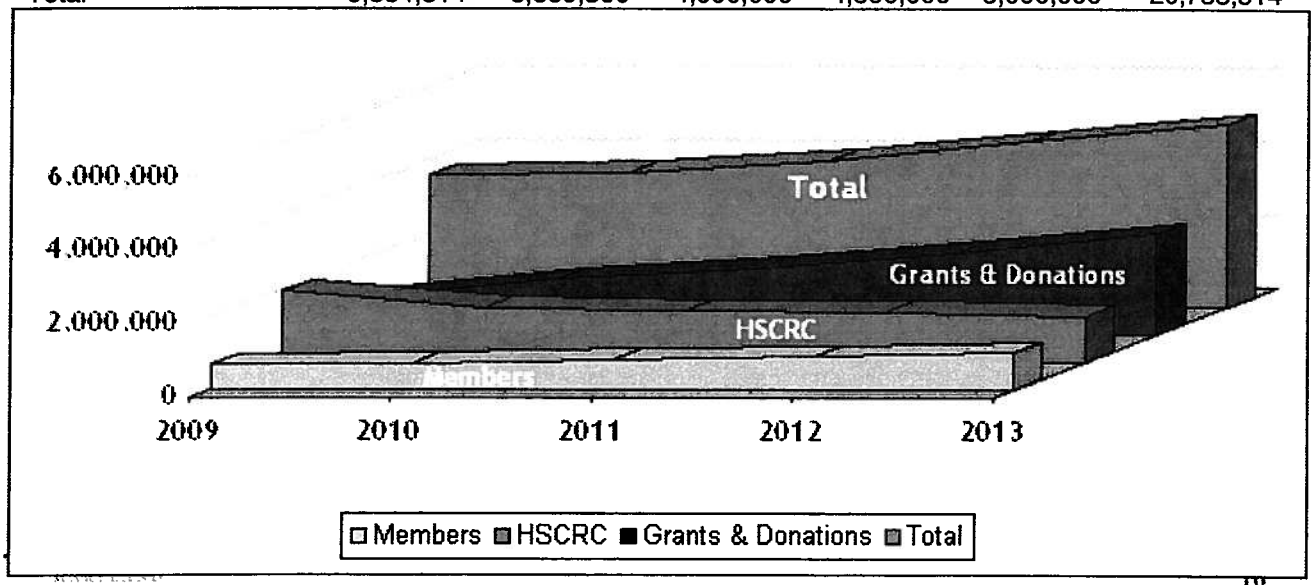
Scenario 1: Gradual Drop of HSCRC support (-$100,000 per year)

	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



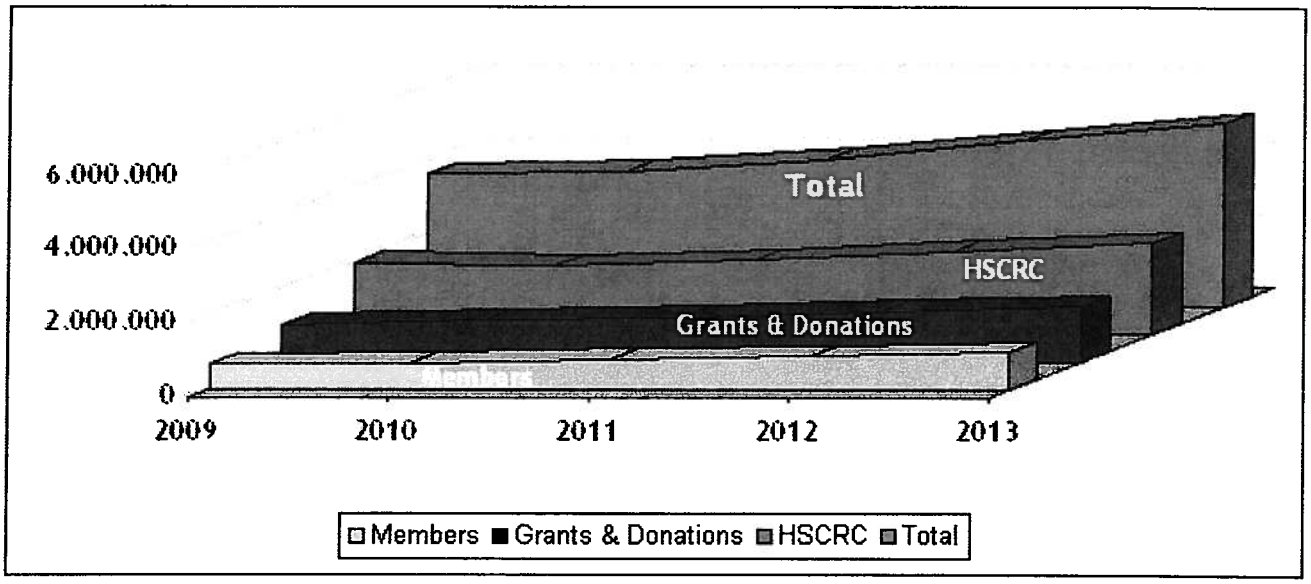
Scenario 2: HSCRC support at 40% match of Expenses in FY10, -5% per year thereafter

	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.

Draft Recommendations for Revisions to the HSCRC's Charge per Visit Methodology

June 3, 2009

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

This document is a draft staff recommendation for discussion purposes only. Please send comments to Char Thompson (cthompson@hscrc.state.md.us) by **June 24, 2009.**

Background:

Outpatient revenue at Maryland hospitals has been increasing much faster than approved outpatient rate increases. At its June 4, 2008 meeting, the Commission approved the Charge per Visit (CPV) methodology as a means to limit the rate of increase in the revenue per case-mix adjusted outpatient visit at each hospital. Using a base year of data, the CPV methodology establishes a hospital specific CPV target which is the allowable average charge per outpatient visit for the subsequent year. The target is adjusted for rate increases, for an intensity factor to allow for changes in technology, and for changes in case-mix .

The CPV system includes ambulatory surgery, emergency department, and clinic visits. The outpatient visits are segregated into 3 groups: 1) Those that include a significant procedure Ambulatory Patient Group (APG); 2) visits with a medical APG and no significant procedure APG; and 3) visits with no significant procedure or medical APG. Only groups 1 and 2 are included in the CPV, and the visits in the third group, along with excluded visits, are treated as a pass-through and subject to unit rate compliance. Under the current exclusion logic, 55% of total outpatient revenue is included under the CPV.

Since adoption of the CPV methodology, the Commission staff, with guidance from the Outpatient Technical Workgroup, has been working to address issues that, due to time constraints, could not be incorporated into the original CPV recommendation. The following are recommended revisions to the CPV exclusion logic as well as recommended refinements to the case-mix methodology. Under these recommended revisions to the exclusion logic, approximately 80% of outpatient revenue will be included under the CPV.

Revisions to the CPV Exclusion Logic:

When the CPV methodology was originally being proposed, it was expected that FY 2007 outpatient data would be used as the base to set the CPV target for FY 2008. The FY 2007 data did not include the variable "number of visits," a field included in the data submission regulations beginning FY 2008. The majority of the records in the outpatient data represent one outpatient visit. The "number of visits" field is used to identify records/claims that include more than one outpatient visit due to "cycle-billing." A cycle-billed claim is a claim that remains open because the patient is expected to return at regular intervals for treatment. Because the FY 2007 data did not include information regarding the number of visits represented by each record, Commission staff identified the kinds of outpatient visits that were "likely" to be cycle-billed (chemotherapy, pharmacotherapy, radiation therapy, psycho-therapy, and dialysis) and excluded these types of visits from the CPV. This method excludes revenue beyond that represented by cycle-billed visits. Commission staff recommends that the exclusion of cycle-billed records be based on the "number of visits" field (record would be excluded if number of visits > 1) for FY2010. This will be a temporary measure while staff investigates the best way to include multiple visit records under the CPV.

Outpatient records with APGs that represent the following radiology procedures are also currently excluded from the CPV: MRI, CAT scan, myelography, mammography, ultrasound

(except obstetric), PET scan, angiography, and diagnostic nuclear medicine. Analysis indicated that visits through the emergency department that included these APGs had significantly higher charges compared to referred ambulatory visits with the same APG. Because there was insufficient time to develop a refinement to the case-mix methodology that would address this issue, staff recommended that visits with the above radiology APGs be excluded from the CPV. In the last several months, staff has developed a refinement to the case-mix methodology that provides a separate case-mix weight for the radiology APGs when the visit occurs in the emergency department or clinic. Staff recommends that this refinement to the case-mix methodology be implemented in FY 2010. Because the added resource use associated with visits to the emergency department or clinic will be reflected in the case-mix, staff also recommends that visits with radiology APGs no longer be excluded from the CPV in FY 2010.

The third and final recommended revision to the exclusion logic involves the infusion APGs (APG 110 = pharmacotherapy by extended infusion, APG 111 = pharmacotherapy except by extended infusion). These two APGs were excluded from the CPV because analysis showed that there was a large dispersion in the total charges within these APGs due to large differences in the associated drug charge. Staff is recommending a refinement to the case-mix grouping methodology for these APGs based on the 10 classes of associated drug APGs (APGs 430-439) in the record. Because this refinement, in addition to a trim methodology for outlier drug charges, significantly reduces the dispersion in total charges within the infusion APGs, staff recommends that the infusion APGs be included under the CPV in FY 2010.

Case-mix Refinement for Multiple Significant Procedures:

Of the included significant procedure visits, 88% have a single significant procedure performed during the visit (referred to as "singletons") and therefore have one significant procedure APG in the record. The remaining significant procedure visits have 1-2 additional APGs in the record. The current significant procedure case-mix methodology for visits with multiple procedures is based on the highest weighted APG in the record. Therefore, the case-mix weight assigned to a visit with multiple procedures is equal to a visit where a single procedure is performed. Comments from the industry have suggested that the current methodology may be unfair to hospitals that perform multiple procedures within a single visit. Based on these comments, staff is recommending for FY 2010 that visits with multiple significant procedures be given a separate weight if the secondary significant procedure APG has a singleton weight greater than 1.0.

Summary of Recommendations:

Staff recommends the following revisions to the current CPV methodology for FY 2010:

1. Exclude cycle-billed visits based on the "number of visits" field (record excluded if number of visits >1) instead of visit types thought to be cycle-billed.

2. Implement the recommended refinement to the case-mix methodology that would give appropriate case-mix weight for radiology procedures performed in the

emergency department or clinic and no longer exclude these APGs from the CPV system.

3. Implement the recommended refinement to the case-mix grouping methodology for infusion APGs (110, 111) based on the associated drug APGs (430-439), and no longer exclude the infusion APGs from the CPV system.

4. Implement the recommended refinement to the case-mix methodology to reflect the added resource use for visits where multiple significant procedures are performed.

Draft Recommendations to Modify the Case Mix Methodology for Involuntary Psychiatric Admissions, and the FY 2010 Case Mix Adjustments

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

June 3, 2009

This document contains staff draft recommendations for discussion purposes only. No Commission action is required at this time. Public comments should be sent to Nduka Udom at the above address or by e-mail at ndukau@hscrc.state.md.us. For full consideration, comments should be received by June 24, 2009.

Draft Recommendation to Modify the Case Mix Methodology for Involuntary Psychiatric Admissions

Purpose

The purpose of this recommendation is to split the twelve APR-DRGs in MDC 19 that classify psychiatric patients into various diagnosis groups based on the involuntary nature of their admission. In fiscal year 2003, the Health Services Cost Review Commission began collecting on the Inpatient Discharge Abstract information on psychiatric patients who are involuntarily admitted to acute care hospitals in Maryland. Staff believes that these patients constitute a unique set of psychiatric patients with higher resource intensity that are not accurately captured by the core grouping logic of the APR-DRG grouper. Staff also believes a distinction based on voluntary and involuntary admission will enhance the case mix methodology for psychiatric cases and more accurately align hospital payment with resource utilization under the Charge-Per-Case system.

Background

To parallel this recommended change to MDC 19, in 2005, when the Commission adopted the use of the APR-DRG grouper for measuring case mix growth at Maryland hospitals, it also approved the augmentation of APR-DRG 860. Rehabilitation cases grouped to APR-DRG 860 are reclassified under the existing Maryland logic to the 9 rehab DRGs. This augmentation has enhanced the classification of rehabilitation cases and has more accurately aligned payment to Maryland hospitals that treat these cases to resource utilization.

Prior to the implementation of APR-DRGs, the Commission also approved allowing MDC 19 cases that meet certain criteria to have additional payment or "outlier trim revenue" in a non-revenue neutral per diem basis in an acknowledgement of the fact that the APR-DRG grouper (like other groupers) does not adequately explain the variation in resource use across these cases. While this approach has allowed some relief to the institutions with long lengths of stay without diminishing the approved revenue allocated to existing psychiatric cases, demand for hospital psychiatric services has risen as public providers of care have scaled back resources. Hospitals have generally noted that psychiatric services require extensive patient supervision.

Since the implementation of APR-DRGs in Maryland, there are ongoing efforts to quantify the various components of psychiatric resource utilization in order to more accurately classify psychiatric patients into diagnosis groups that accurately reflect and align payment to resource utilization. One such effort is the 3M Health Information Systems' collaboration with the Health Services Research and Development Center at Johns Hopkins University, and The Hilltop Institute at University of Maryland Baltimore County to improve inpatient psychiatric payment. Until the core grouping logic of the APR-DRG grouper has been refined in a way to account for differences in resource utilization among various subsets of the inpatient psychiatric patients, staff believes that an augmentation to the current APR-DRG scheme as used by the Commission for measuring case mix growth in Maryland hospitals is necessary.

Data Analysis

Staff has performed a number of analyses based on splitting the twelve APR-DRGs in MDC 19 that classify psychiatric patients into various diagnosis groups based on the involuntary nature of their admission. These analyses were done using FY 2008 case mix data. The results suggest that the additional 48 cells created by splitting the twelve APR-DRGs in MDC 19 would improve by 4.61 percent the explanatory power regarding the accuracy of predicting and aligning payment to Maryland hospitals that treat psychiatric patients to resource utilization over the current methodology (from 0.128 to 0.134). The results of this modeling are presented in Tables 1 and 2.

Recommendation

Staff recommends that psychiatric cases be grouped by the APR-DRG grouper. The cases should then be reclassified into two categories: voluntary admission and involuntary admission. As each case is regrouped to a new psychiatric APR-DRG, the case would carry with it the severity of illness assigned by the APR-DRG grouper. Case weights would then be developed for each DRG/severity cell. This approach would be effective July 1, 2009 (FY2010).

TABLE 1

THE RESULT OF THE PROPOSED METHODOLOGY USING FISCAL YEAR 2008 DATA

APR DRG CODE	APR DRG CODE DESCRIPTION	SEVERITY CODE	SEVERITY CODE DESCRIPTION	CURRENT METHODOLOGY		PROPOSED METHODOLOGY			
						VOLUNTARY		INVOLUNTARY	
				NUMBER OF CASES	WEIGHT	NUMBER OF CASES	WEIGHT	NUMBER OF CASES	WEIGHT
740	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	1	MINOR	5	0.813206	5	0.784871	0	1.183597
740	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	2	MODERATE	15	1.605565	11	1.505366	3	2.992698
740	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	3	MAJOR	25	2.106301	24	2.014759	1	4.625233
740	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	4	EXTREME	5	4.820762	5	4.634828	0	7.762397
750	SCHIZOPHRENIA	1	MINOR	410	0.716853	329	0.672154	81	0.840040
750	SCHIZOPHRENIA	2	MODERATE	4,335	0.791580	3,465	0.742221	869	0.951957
750	SCHIZOPHRENIA	3	MAJOR	1,542	1.107002	1,369	1.037975	172	1.061991
750	SCHIZOPHRENIA	4	EXTREME	42	2.026614	38	1.900245	5	2.589680
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSE	1	MINOR	759	0.512799	660	0.520075	99	0.465448
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSE	2	MODERATE	5,153	0.633611	4,733	0.636456	420	0.604140
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSE	3	MAJOR	2,651	0.722994	2,507	0.719985	144	0.781481
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSE	4	EXTREME	235	2.438443	227	2.410616	10	2.140429
752	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1	MINOR	3	0.373534	3	0.380969	0	0.330348
752	DISORDERS OF PERSONALITY & IMPULSE CONTROL	2	MODERATE	25	0.451217	23	0.461914	2	0.398218
752	DISORDERS OF PERSONALITY & IMPULSE CONTROL	3	MAJOR	13	0.825895	12	0.801678	1	0.657538
752	DISORDERS OF PERSONALITY & IMPULSE CONTROL	4	EXTREME	0	1.060124	0	1.060343	0	1.060343
753	BIPOLAR DISORDERS	1	MINOR	951	0.577103	852	0.572930	99	0.611104
753	BIPOLAR DISORDERS	2	MODERATE	6,414	0.690722	5,770	0.682645	643	0.764884
753	BIPOLAR DISORDERS	3	MAJOR	3,019	0.748928	2,830	0.732922	188	1.011251
753	BIPOLAR DISORDERS	4	EXTREME	150	2.051952	138	2.110140	12	1.801261
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	1	MINOR	655	0.360970	609	0.363576	46	0.326802
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	2	MODERATE	1,520	0.463727	1,448	0.465185	72	0.434916
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	3	MAJOR	719	0.545077	687	0.543380	31	0.596662
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	4	EXTREME	16	1.297251	15	1.334889	1	1.598742
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGN	1	MINOR	349	0.374401	304	0.375652	45	0.366513
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGN	2	MODERATE	286	0.530061	268	0.546495	17	0.485327
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGN	3	MAJOR	84	0.697414	81	0.707607	3	0.932995
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGN	4	EXTREME	4	1.486327	4	1.490870	0	1.259607
756	ACUTE ANXIETY & DELIRIUM STATES	1	MINOR	527	0.392423	520	0.393816	7	0.295212
756	ACUTE ANXIETY & DELIRIUM STATES	2	MODERATE	305	0.547301	301	0.544360	4	0.460474
756	ACUTE ANXIETY & DELIRIUM STATES	3	MAJOR	130	0.703482	128	0.708124	2	0.672505
756	ACUTE ANXIETY & DELIRIUM STATES	4	EXTREME	23	2.220947	23	2.223362	0	2.558766
757	ORGANIC MENTAL HEALTH DISTURBANCES	1	MINOR	50	0.612449	47	0.618174	3	0.959167
757	ORGANIC MENTAL HEALTH DISTURBANCES	2	MODERATE	360	0.714480	346	0.695551	14	1.148308
757	ORGANIC MENTAL HEALTH DISTURBANCES	3	MAJOR	299	0.888748	291	0.883953	9	1.342550
757	ORGANIC MENTAL HEALTH DISTURBANCES	4	EXTREME	35	1.265898	35	1.266029	0	2.556070
758	CHILDHOOD BEHAVIORAL DISORDERS	1	MINOR	61	0.622029	53	0.584697	8	0.496362
758	CHILDHOOD BEHAVIORAL DISORDERS	2	MODERATE	195	0.706898	167	0.740106	29	0.542824
758	CHILDHOOD BEHAVIORAL DISORDERS	3	MAJOR	48	0.744204	43	0.746083	5	0.642550
758	CHILDHOOD BEHAVIORAL DISORDERS	4	EXTREME	0	1.116945	0	1.117175	0	1.117175
759	EATING DISORDERS	1	MINOR	6	1.372535	6	1.337036	0	1.008904
759	EATING DISORDERS	2	MODERATE	30	1.645161	30	1.572814	0	1.159625
759	EATING DISORDERS	3	MAJOR	49	3.003952	48	2.747953	2	3.588422
759	EATING DISORDERS	4	EXTREME	9	4.057660	8	3.843079	1	7.440395
760	OTHER MENTAL HEALTH DISORDERS	1	MINOR	37	0.612398	32	0.640241	5	0.329739
760	OTHER MENTAL HEALTH DISORDERS	2	MODERATE	118	0.733727	110	0.763967	8	0.446375
760	OTHER MENTAL HEALTH DISORDERS	3	MAJOR	58	1.063477	55	1.100234	3	0.787266
760	OTHER MENTAL HEALTH DISORDERS	4	EXTREME	3	3.394409	3	3.467889	0	4.274732

TABLE 2
STATISTICAL SUMMARY OF THE REGRESSION RESULTS

Proposed Methodology (All Cases)				
R-Square	0.5384			
Adjusted R-Square	0.5384			
Variable:	**Parameter Estimate**	**Standard Error**	**t Value**	**P-Value (Pr > |t|)**
Casemix Weight	11559	12.37215	934.25	<0.0001
Proposed Methodology (Psychiatric Cases)				
R-Square	0.1339			
Adjusted R-Square	0.1339			
Variable:	**Parameter Estimate**	**Standard Error**	**t Value**	**P-Value (Pr > |t|)**
Casemix Weight	11962	170.76743	70.05	<0.0001
Current Methodology (All Cases)				
R-Square	0.5383			
Adjusted R-Square	0.5383			
Variable:	**Parameter Estimate**	**Standard Error**	**t Value**	**P-Value (Pr > |t|)**
Casemix Weight	11561	12.37590	934.14	<0.0001
Current Methodology (Psychiatric Cases)				
R-Square	0.1280			
Adjusted R-Square	0.1279			
Variable:	**Parameter Estimate**	**Standard Error**	**t Value**	**P-Value (Pr > |t|)**
Casemix Weight	11594	169.92468	68.23	<0.0001

Draft Recommendation for FY 2010 Casemix Adjustments

Background

The FY2010 rate update approved by the Commission consists of two components: a base update and an allowance for case mix growth. The Commission was presented with two very different proposals:

- A staff proposal calling for 0.49% base update with a 1.0% limit for case mix growth; and,
- A hospital industry proposal calling for 2.72% base update with a 0.75% limit for case mix growth.

The Commission's final decision reflected a compromise between the two proposals: a base update of 1.49% with a 0.5% limit for case mix growth. In keeping with the policy for adjusting case mix growth in FY09, it would be assumed that case mix would be adjusted proportionately if actual measured casemix growth exceeded 0.5%. A proportional case mix adjustment means that if, for example, overall system case mix grows by 1.0%, and there were no hospitals with negative case mix growth, then all hospitals would have their allowed case mix growth adjusted by multiplying by one half to provide an overall increase of 0.5%. (0.5% allowed/1.0% measured). Thus, in that situation:

- Hospital measured case mix growth of 0.6% will result in allowed case mix growth of 0.3% (0.6% x .5); and,
- Hospital measured case mix growth of 6.0% will result in allowed case mix growth of 3.0% (6.0% x .5).

Problem

The base update for FY10 rate year is low when compared to previous updates. The policy of proportionally adjusting every hospital's case mix growth may have the unintended consequence of severely limiting resources for hospitals that experience real additional costs due to significant case mix growth. The allowance for case mix in hospital charge targets is intended to allow hospitals to receive the resources necessary to account for the additional costs associated with treating higher need patients.

The rate setting system expects that hospitals will manage their available resources effectively and, where possible and necessary, capture available cost savings. In a more typical year, when the base update is relatively generous, a restricted level of case mix growth may be problematic but hospitals have room to adjust for the costs of case mix growth within the larger context of general revenue growth.

In the current environment, when the base update is quite low, hospitals experiencing significant growth in case mix and its attendant costs will face an especially daunting management challenge. Consider the two hypothetical hospitals:

- Hospital A had measured case mix growth of 0.6% which resulted in allowed case mix growth of 0.3%. This hospital will likely react with a combination of the following: improve efficiency, find cost savings, and/or reduce operating margin to cover the 0.3% percent difference between actual case mix and the amount built into rates. This is a management challenge, but an achievable one.

- Hospital B had measured case mix growth of 6.0% which resulted in allowed case mix growth of 3.0%. This hospital will have the same combination of tools at its disposal as Hospital A (improved efficiency, cost savings, lower margins, etc) but must make up a much larger 3.0% difference. Obviously, the management challenge facing Hospital B is far more daunting.

Note, that while these hospital examples are hypothetical, this range or difference in measured case mix across hospitals is quite common in any given year.

Recommendation

It is the goal of the rate setting process to provide hospitals with charge targets that, assuming efficient operation, can be met by hospitals. The strict imposition of a proportional adjustment for case mix is contrary to that goal. Staff believes the following recommendation will result in a more equitable distribution of scarce resources among hospitals.

As noted earlier, the Commission approved update included a compromise suggested by the hospital industry. This update called for relatively more base update and a relatively low allowance for case mix growth. The approved rate update provided all hospitals a base update of 1.49% and statewide case mix growth of 0.5%. Staff recommends that this amount of case mix growth be accounted for when apportioning the 0.5% of case mix growth allowed for the FY 2010 rates. The purpose of this recommendation is to allow hospitals with significant growth in case mix to receive additional resources to allow them to cover the cost associated with treating higher need patients.

Staff recommends the following steps in calculating case mix growth:

- Step 1. For each hospital, the first 0.6% of case mix growth will be treated as equal to 0. The 0.6% reflects the 0.5% in case mix included in the base rate, adjusted to reflect the variable cost (85%) associated with increased volume.

- Step 2. Calculate the overall case mix growth based on the adjustment in Step 1. This may be sufficient to achieve the desired case mix growth. If not, proceed to step 3.

- Step 3. Calculate a proportional adjustment factor to achieve the 0.5% case mix growth target.

- Step 4. Calculate a hospital's allowed case mix based on its individual experience. (((Hospital Measured Case Mix) – (0.6% case mix in base)) * Case mix adjustment factor).

BRIEFING ON ACHIEVED AND EXPECTED OUTCOMES OF THE NURSE SUPPORT PROGRAM II

JUNE 3, 2009

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Ave.
Baltimore, MD 21215

Nurse Support Program II
Recap of First Three Years of the Program
September, 2008

In May, 2005, the Health Services Cost Review Commission (HSCRC) unanimously approved an increase of 0.1% of regulated patient revenue for the use of expanding the pool of nurses in the State. A committee of deans and directors of nursing programs helped design this program, Nurse Support Program II, funded at approximately $8.8 million per year over a ten-year period. This program focuses on the education of nurses, including educating nurses to become the faculty members so desperately needed.

HSCRC contracted with the Maryland Higher Education Commission (MHEC) to administer the Nurse Support Program II. On behalf of HSCRC, the Maryland Higher Education Commission is also responsible for (1) the development of applications and guidelines, (2) overseeing the review and selection of applicants, and (3) the monitoring and evaluation of recipients of NSP II awards. Monthly NSP II payments are transferred from Maryland hospitals to MHEC and distributed by MHEC to institutions of higher education, hospitals, faculty, and students selected to receive NSP II funding.

MHEC provides the programmatic and administrative support necessary to successfully administer the NSP II program. As the coordinating board for all Maryland institutions of higher education, MHEC contributes its extensive experience and expertise with (1) the management of institutional grants, (2) the administration of student financial aid, and (3) the collection, review, and evaluation of programmatic and financial data from Maryland's higher education institutions. In addition, MHEC is responsible for working collaboratively with Maryland's colleges, universities, and community colleges to address workforce needs, including the State's critical nursing shortage.

Under the Nurse Support Program II, funding supports two types of initiatives:

1. Competitive Institutional Grants
2. Statewide Initiatives

Both are administered by MHEC, and allow institutions and individuals throughout the State who are involved in nursing education to benefit from the Nurse Support Program II. The Competitive Institutional Grants fund the providers of nursing education, and the Statewide Initiatives fund individual students or faculty members.

NSP II is now funding 19 Competitive Institutional Grants for schools of nursing, which are either working alone or are affiliated with other schools and/or hospitals, for a total awarded amount of $14,905,026.

Types of programs funded are:

- Admitting nontraditional students, such as EMTs, into specialized programs;
- Increasing the number of nursing students admitted;
- Increasing the retention of admitted students through tutoring, mentoring, review classes;
- Instituting accelerated programs leading to RNs;
- Providing a pipeline for students to obtain BSNs and MSNs;
- Transferring nursing classes to distance-learning modes and sharing these classes among schools;

- Conducting remote classes within hospitals;
- Educating new faculty in Master's and Doctoral programs.

Now in their third year, the initial 7 projects are beginning to show results:

- 19 new faculty members have been hired;
- 539 additional students were admitted to nursing programs;
- 14 new courses were initiated, most in a distance-learning format to share with other schools;
- 122 new graduates, 8 of whom will be new faculty.

Through the Statewide Initiatives, NSP II assists individual students and faculty.

Graduate students are supported by the Graduate Nursing Faculty Scholarships and the Living Expenses Grants. Graduate students accepting these grants must agree to become faculty members in Maryland schools of nursing upon graduation. In the past three years, 109 students have been awarded $708,987 in scholarships, and $1,041,160 has been awarded as living expenses grants to 56 of these students, allowing them to return to school to become the next generation of faculty.

Over the past three years, NSP II has supported undergraduate nursing students by supplementing the Workforce Shortage Student Assistance Grant Program with an additional $600,000 for scholarship awards to undergraduate nursing students. This past year, support has also been given to the Janet L. Hoffman Loan Assistance Repayment Program, which helps working nursing faculty repay their student loans.

Another award given through NSP II is the New Nursing Faculty Fellowships, which are given to full-time, tenure-track faculty hired by schools of nursing within the past year. The individual award amount is $20,000, with $10,000 given to the faculty member their first year, and $5,000 in each of the next two years. This money may be used as a hiring bonus, to help pay educational loans, for professional development, and other relevant expenses. Over the first three years, 52 new faculty members have been awarded $840,000.

During the first three years of its ten-year existence, NSP II has committed over $18,000,000 to the education of new bedside nurses and new nursing faculty in order to alleviate the nursing shortage. From 2006 to 2008, the number of nursing degrees awarded in Maryland increased by 273. Of those 273 degrees, 224 of them were given by the fourteen schools with NSP II grants. Because the Graduate Nursing Scholarship requires a two-year service obligation as a nursing faculty for each award year, and the Workforce Shortage Student Assistance Grant requires a one-year service obligation as a nurse for each award year, NSP II is making a significant contribution to the Maryland nursing shortage.

NURSE SUPPORT PROGRAM II

	Lead Institution	Consortium Members	Program Description	Program Duration	Projected Outcomes	Outcomes to Date	Funding to Date	Total Funding
FY 2007								
NSP II-06-104	College of Southern Maryland	Calvert Memorial Hospital, Civista Medical Ctr., St. Mary's Hospital	Increase faculty by 2 FTEs; student retention; transition new nurses to hospital	5 years	Increase enrollment by 25% (50 students)	81 additional graduates; 1 additional faculty hired	$ 400,000	$ 1,075,000
NSP II-06-105	University of Maryland Baltimore	UMMC, Franklin Sq. Hospital	Master's preparation of hospital-based nurses	5 years	100 Master's prepared nurses	3 additional graduates; 83 additional students admitted	$ 700,000	$ 1,325,000
NSP II-06-106	Harford Community College	Upper Chesapeake	Fast-Track 15 month ADN Program; student retention initiatives	4 years	96 additional ADN graduates	24 additional graduates; 52 additional students admitted; 72 review sessions	$ 306,302	$ 662,792
NSP II-06-107	Anne Arundel Community College	Villa Julie College; College of So. Md.	RN-to-BSN concurrent enrollment option	3 years	64 RN-to-BSN students	1 additional student admitted	$ 322,813	$ 327,813
NSP II-06-110	University of Maryland Baltimore	None	Practice-focused doctoral program	5 years	125 - 184 nurse DNPs	29 additional students admitted; 1 new faculty hired	$ 360,000	$ 1,020,000
NSP II-06-122	Villa Julie College (Stevenson)	Carroll Comm. Hospital, Union Memorial Hospital, Upper Chesapeake	RN to BSN Program	4 years	96 additional BSN students; 200 RN to BSN students	70 additional BSN students admitted; 1 new faculty hired	$ 536,655	$ 1,084,631
NSP II-06-126	Coppin State University	Md. General Hospital Kernan Hospital; Union Memorial Hospital	BS to MSN program using current hospital-based nurses	5 years	Enroll 50 additional students; graduate 40 MSN nurses & recruit 9 into faculty positions	14 additional students admitted; 8 new faculty hired	$ 115,000	$ 560,000
			TOTAL FUNDING OF FY 2007 PROJECTS				$ 2,625,770	$ 5,495,236
FY 2008								
NSP II-08-105	College of Notre Dame	Good Samaritan; Harbor Hospital; St. Agnes Hospital	Increase BSN nurses; increase retention; begin MSN/Ed. Focus	5 years	425 additional BSNs; 66 additional MSN/Ed; retention rate of 85%	106 RN-BSN and 17 MSN additional students admitted	$ 295,283	$ 1,375,978
NSP II-08-106	Comm. Col. Of Baltimore County	Allegany College & Chesapeake College	EMT to RN program by distance learning	3 years	192 students over 3 yrs	8 additional students admitted	$ 110,862	$ 295,005
NSP II-08-107	Comm. Col. Of Baltimore County	Mercy Med. Ctr; St. Agnes Hosp., Union Memorial Hospital	Increase retention by clinical tutoring, mentoring & nurse success class	3 years	Retain 282 students	5 tutors provided 603 hours of assistance	$ 131,449	$ 396,033
NSP II-08-111	Hagerstown Comm. College	Washington Co. Health System	Increase pre-nurse students; outreach to minorities; increase retention	5 years	202 additional students	23 additional students admitted; 2 new faculty hired	$ 224,760	$ 1,029,140
NSP II-08-114	Johns Hopkins Univ.	Howard Co. Hospital, St. Agnes Hospital, Mercy Medical	On-line graduate courses for hospital staff & support during coursework	5 years	125 DNPs	25 additional students admitted	$ 351,673	$ 970,299
NSP II-08-116	Prince George's Comm. College	MedStar (Good Sam): Drs. Comm. Hospital	Increase enrollment in LPN to RN prog. & retention: satellite prog. At Good Sam's Hospital	5 years	240 more students; hire new faculty	38 additional students admitted	$ 81,967	$ 876,052
NSP II-08-117	Salisbury University	none	Create CNE & RN to MSN tracks; some distance learning courses	3 years	14 Nurse Educators; 5 MSNs	10 additional RN-MSNstudents admitted; 2 new courses initiated	$ 112,794	$ 261,009
NSP II-08-119	Towson University	Sheppard Pratt; GBMC; Frederick Mem. Hospital	MS/nurse ed. or admin. program; distance learning; add. clinical sites	5 years	80 MS & 25 BSN students	14 MSNs & 4 RN-BSN additional students admitted; hired 2 faculty	$ 219,182	$ 445,357
NSP II-08-123	Wor-Wic Comm. College	Atlantic Gen. Hosp.; Peninsula Reg. MC	Expand LPN & RN program by sharing resources & adding faculty	3 years	96 students added	32 additional students admitted	$ 75,112	$ 284,520
			TOTAL FUNDING OF FY 2008 PROJECTS				$ 1,603,082	$ 5,933,393
FY 2009								
NSP II-09-101	Allegany Comm. Coll	Western Md. Health System, Garrett Memorial Hospital	Establish nursing program in Garrett Co. - Double capacity of evening program in Allegany Co	5 years	80 graduates	First year of project	$ 162,031	$ 993,052
NSP II-09-103	U. of MD. Baltimore	None	Use online and blended learning methods with flexible schedule in DNP program	5 years	136 new faculty	First year of project	$ 213,394	$ 1,308,095
NSP II-09-104	U. of MD. Baltimore	None	nursing students into teaching certificate program	3 years	200 new faculty	First year of project	$ 111,079	$ 499,990
			TOTAL FUNDING OF FY 2009 PROJECTS				$ 486,504	$ 2,801,137

Please Note: All Outcomes and Funding to Date are as of September, 2008. Updated figures will be available in September, 2009.

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 and 19-214, Annotated Code of Maryland

NOTICE OF EMERGENCY ACTION

The Health Services Cost Review Commission has granted emergency status to **Regulation .03D** under **COMAR 10.37.10 Rate Application and Approval Procedures.**

Emergency Status Begins: **July 1, 2009**

Emergency Status Expires: **October 31, 2009**

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is no economic impact.

.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

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 EMERGENCY ACTION

The Health Services Cost Review Commission has granted emergency status to **Regulation .26B** under **COMAR 10.37.10 Rate Application and Approval Procedures.**

Emergency Status Begins: **June 1, 2009**

Emergency Status Expires: **October 31, 2009**

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is no economic impact.

.26 Differentials

A. Text Unchanged.

B. Working Capital Differentials – Payment of Charges.

(1)-(2) Text Unchanged.

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(4) Hospital Billing Responsibilities.

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(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.

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

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(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
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
AREA CODE 410-764-2605
FAX 410-358-6217
Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

TO: **Commissioners**

FROM: **Legal Department**

DATE: **May 29, 2009**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

July 1, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
August 5, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**

Please note, Commissioner packets will be available in Commission offices at 8:00 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