STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

DEC 2 3 2009

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
131 Lowe House Office Bldg.
Annapolis, MD 21401-1991

RE: 2009 Joint Chairmen's Report (p. 98) – Report on Long-Term Care Incentive Payments and "Never Events"

Dear Chairmen Currie and Conway:

The 2009 Joint Chairmen's Report (p. 98) requested that the Department submit a report detailing how the Medicaid program provides or plans to provide incentive payments to long-term care facilities and community providers to reward quality care. The JCR also requested that the Department include information about the extent to which "never events" occur in long term care facilities and with community providers, as well as the cost of these events to the State.

The enclosed report describes how the Medicaid program plans to provide incentive payments to long term care facilities in order to reward quality care. Pursuant to HB 782/SB 664 (Chapters 417 and 418 of the Acts of 2009), a workgroup was convened to assess the State's current long term care reimbursement methodology. In conjunction with the workgroup's review of the current methodology, we intend to explore if there are procedures or behaviors, in nursing facilities and among community providers, that should not occur and therefore should not be reimbursed, i.e., "never events." For example, the program currently does not pay for decubitus ulcer care in a nursing facility if it is determined that the ulcers were the result of the facility's failure to provide appropriate care. The committee will be exploring whether there are other occurrences of this nature for which payment should be withheld.

The Department will submit a report to the General Assembly on October 1, 2010, as required by HB 782/SB 664, that will make recommendations regarding suggested changes to

the current long term care reimbursement methodology. This report will incorporate how the Department intends to provide quality incentive payments to nursing facilities as well as community providers and the extent to which "never events" may be addressed in a new reimbursement methodology.

If you have questions or need more information on this topic, please contact Shawn Cain, Assistant Director of the Office of Governmental Affairs, at (410) 767-6509.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: John G. Folkemer
Shawn Cain
Mark A. Leeds
Tricia Roddy
Christa Speicher
Susan J. Tucker

Nursing Home Pay-for-Performance
December 1, 2009

Introduction/Charge

HB 782/SB 664 (Ch. 417 and 418 of the Acts of 2009) direct the Department of Health and Mental Hygiene to review the current pay-for-performance methodology on or before December 1, 2009, and each year thereafter, in consultation with interested stakeholders and representatives of nursing facilities. The Department is required to make necessary changes and modifications to include development of improvement measures. HB 782/ SB 664 also instructed the Department to score all nursing facilities in Maryland based on the 2008 criteria submitted to the General Assembly, but that funds were not to be allocated for distribution to nursing facilities based upon the scores in Fiscal Year 2010. In accordance with this legislation, on July 1, 2009 the Department sent each nursing facility in Maryland a transmittal indicating their scores and payments they would have received.[1]

Background

SB 101 (Ch. 503 of the Acts of 2007) authorized the Department to initiate a quality assessment on certain nursing facilities in Maryland in order to restore cost containment rate reductions to nursing facilities in the Maryland Medicaid Program. It was also established under SB 101 that up to 25 percent of the revenue generated by the quality assessment shall be distributed to nursing facilities based on accountability measures that indicate quality care or a commitment to quality of care.

SB677/HB 809 (Ch. 199 and 200 of the Acts of 2008) directed the Department to develop a plan for accountability measures to use in a pay-for-performance program to be implemented July 1, 2009. The plan developed by the Department, in consultation with representatives of Maryland nursing facilities and other stakeholders, was submitted to the General Assembly in December of 2008. The plan included program goals, measurement criteria, funding sources, implementation guidelines, and benchmarking periods.

In accordance with HB 782/SB 664, 50 percent of the amount designated for pay-for-performance is to be distributed on July 1, 2010; 100 percent of the pay-for-performance funds is to be distributed beginning July 1, 2011.

Program Goals

The primary goal of Maryland Medicaid's Nursing Home Pay-for-Performance program (P4P) is to improve the quality of care for nursing home residents. Increasingly, health care payers and insurers are incorporating quality of care as one of the criteria used in reimbursement methodologies, thus, linking pay to performance.[2] As Medicaid is the

[1] See Appendix B for P4P rankings, scores, and payment amounts for eligible facilities.
[2] Hazelwood, Anita, and Ellen D. Cook. "Improving Quality of Health Care Through Pay-For-Performance Programs." The Health Care Manager 27(2008):104-112.

largest payer for nursing facility care, a quality incentive program – or P4P initiative – has the potential to have a major impact on the quality of care for all nursing facility residents.[3]

To assure adequate consultation, a workgroup was formed for planning, discussion, and collaboration on the development of a P4P program.[4] The Hilltop Institute at the University of Maryland, Baltimore County (Hilltop) provided technical assistance and collaboration in developing the methodology for a P4P program.

P4P Measures

In collaboration with the workgroup, the Department developed a P4P model through which eligible providers will receive a composite score based upon multiple quality measures, in order to determine qualification for an incentive payment. The measures are as follows:

- Maryland Health Care Commission Family Satisfaction Survey (40%)
- Staffing Levels and Staff Stability in Nursing Facilities (40%)
- MDS Quality Indicators (16%)
- Employment of Infection Control Professional (2%)
- Staff Immunizations (2%)

1. Maryland Health Care Commission Family Satisfaction Survey

   Quality of life is a crucial component in any program linking pay to performance. In order to measure this component, the *Maryland Nursing Facility Family Survey* conducted by the Maryland Health Care Commission will be utilized in P4P. This survey is distributed annually in the fall to families and representatives of Maryland nursing facility residents.

   The workgroup decided to score facilities based on responses to the following questions from the survey:

   - Overall Experience
     - Would you recommend this nursing home?
     - How would you rate the care in this nursing home?
   - Five Domains which are comprised of multiple questions
     - Staff and Administration of the Nursing Home
     - Physical Aspects of the Nursing Home
     - Autonomy and Resident Rights
     - Care Provided to Residents
     - Food and Meals

[3] Kassner, Enid. "Medicaid and Long-Term Services and Supports for Older People." AARP Public Policy Institute. 27 September 2008 http://www.aarp.org/research/assistance/medicaid/fs18r_medicaid_06.html.

[4] See Appendix A for list of workgroup members.

This component will comprise 40 percent of the total P4P score, 20 percent of which will be derived from the five domain scores and 20 percent from questions related to overall experience.

2. Staffing Levels and Staff Stability in Nursing Facilities

In order to evaluate and compare staffing, P4P will utilize the Department's annual Nursing Facility Wage Survey, typically administered in October of each year. Comparison of staff hours and facility census enables the Program to determine average hours of care per resident per day, both on an aggregate and on a facility-specific basis. Using a 4.13 hours standard for a facility with average resident acuity, the Program has set an acuity-adjusted goal for each provider based upon its resident mix.[5] Providers are, therefore, scored on their actual staffing relative to their facility-specific goal.

In addition to the level of nursing staff in facilities, continuity and stability of nursing staff will be measured and collected. The wage survey has been revised by adding a field to capture each staff person's length of employment at the facility.

Stability will be measured by examining the percent of hours provided by nursing staff who have been employed by the facility 2 years or longer.

Staff levels (20%) and staff stability (20%) will comprise 40 percent of the overall score.[6]

3. Minimum Data Set (MDS) Clinical Quality Indicators

In November 2002, CMS began a national Nursing Home Quality Initiative (NHQI). The nursing home clinical quality indicators, as a component of NHQI, come from federally-mandated resident assessment data that nursing homes collect on residents during their stay.

The workgroup decided on the following quality indicators for long-stay residents from the resident assessment data or "Minimum Data Set" (MDS) for use in P4P:

- Percent of High-Risk Residents Who Have Pressure Sores
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents with a Urinary Tract Infection
- Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season

[5] This benchmark is based upon a study by the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Results of the study indicate a strong correlation between staffing levels and quality of care.

- Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination

Data will be utilized from the most recent quarter available. This component accounts for 16 percent of the overall score.

4. Employment of Infection Control Professional
   In accordance with state licensing regulations (COMAR 10.07.02.21), all Maryland nursing facilities are required to employ a trained Infection Control Professional (ICP). The Department will use a tiered point system as follows:

   - Facilities not in compliance with State regulations will receive no points.
   - Facilities meeting the minimum requirement will receive 1 point.
   - Facilities will receive 2 points if:
     - in a 200+ bed facility, an ICP is dedicated full time to infection control responsibilities, or
     - in a facility with fewer than 200 beds, an ICP is dedicated to infection control responsibilities at least 50 percent of the time.

   Data collection will occur in April of each year. This component will comprise 2 percent of the total score.

5. Staff Immunizations
   In addition to the ICP component, the Department will measure the percentage of nursing facility staff (all staff classifications) that have been vaccinated against seasonal influenza.

   The benchmark for staff vaccinations will be 80 percent, which is based on an epidemiological threshold necessary to achieve herd-immunity. Nursing facilities reaching the benchmark of 80 percent for seasonal flu will receive the full 2 points. Facilities under 80 percent will not receive points for this component.

   Data collection will occur in April of each year for the prior months of October through March. The staff vaccination component will comprise 2 percent of the total score.

Facilities Not Eligible for Participation

Per SB 101, continuing care retirement communities (CCRCs) and facilities with fewer than 45 beds are not subject to the quality assessment and consequently, are not eligible for participation in P4P. In addition to these exceptions, the workgroup agreed that nursing facilities with low Medicaid participation will not be eligible for participation in

P4P, since any incentive payment based on too few Medicaid days would not be meaningful.[7]

Additionally, by utilizing the Office of Health Care Quality's (OHCQ) deficiency data, facilities that meet the following criteria would also be excluded from P4P:

1. Any facility currently identified by CMS as a "special focus" facility.

2. Any facility which in the previous 12 months has had a denial of payment for new admissions sanction imposed by OHCQ.

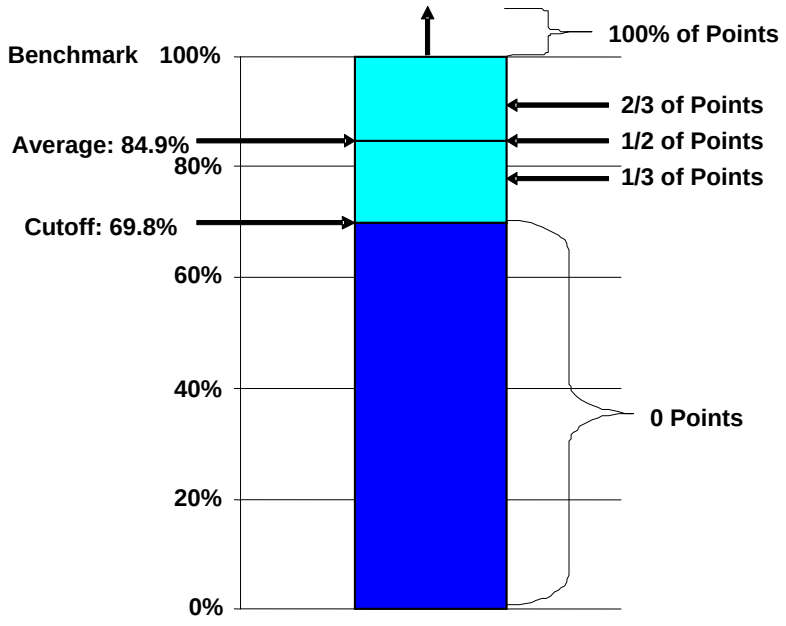
3. Any facility which in the previous 12 months has been identified by OHCQ as delivering substandard quality of care.

Scoring Methodology

Once it has been determined which facilities are eligible for participation in P4P, each facility's raw scores, for each component, are compiled and ranked according to the methodology set forth by the Department.

In order to compare measures and array scores, a methodology that adjusts for variation in point spread is essential. The methodology chosen for P4P provides a context and creates meaningful equivalency across scores by ranking them relative to one another. Scores are arranged between the benchmark and cutoff scores. A score that meets or exceeds the benchmark score always gets 100 percent of points available for that component. The average score gets 50 percent of points available. The cutoff score is the average score minus the difference between the highest and average scores. A score at or below the cutoff score gets no points. Scores between the benchmark and cutoff scores get points proportionate to where the score falls within the range between the highest and cutoff scores. This methodology adjusts for variation in the ranges within measures where some produce scores in a tight range and some measures produce scores in a wider range. Once each measure is scored, a composite score for each nursing facility is created and the facilities are ranked accordingly. The figure below illustrates the methodology.

[7] Low Medicaid proportion is considered 1 standard deviation below the statewide average.



Refinements

HB 782/SB 664 requires the Department to examine the current methodology and make necessary changes and modifications in consultation with stakeholders and nursing facility representatives. The Department met with stakeholders to analyze the methodology and discuss potential revisions. Nursing facilities received their P4P scores in the beginning of July 2009. Once scores were received, providers contacted the Department directly with questions, comments, and suggestions as well as channeled concerns through their appropriate nursing facility representative. Among the items brought to the attention of the Department, there was a strong consensus in the workgroup that eligibility for P4P should be examined. Nursing facility representatives recommended the Department be as inclusive as possible without sacrificing the integrity of the P4P model. Providers expressed a desire to participate in P4P and stakeholders felt as though this represented an area of the model that should be revisited. This section will discuss refinements made to the P4P methodology, mainly related to eligibility for participation in P4P.

Per SB 101, CCRCs and facilities with fewer than 45 beds are not subject to the quality assessment and consequently, are not eligible for participation in P4P. In addition to these exceptions, the workgroup agreed that nursing facilities with low Medicaid participation will not be eligible for participation in P4P, since any incentive payment based on too few Medicaid days would not be meaningful. In the original methodology, low Medicaid proportion was considered 1 standard deviation below the statewide average. The workgroup felt that the use of a standard deviation was a moving target and unpredictable

since it is based on variation around the mean. They also felt as though 1 standard deviation was not inclusive enough of those providers with a significant Medicaid proportion. Hilltop modeled the use of two standard deviations versus the use of one standard deviation and found that only a few additional providers would be eligible for participation in P4P if it was changed to two standard deviations. The workgroup concluded that a cut-off would be more inclusive and predictable and decided that those facilities with Medicaid participation of 40 percent or higher would be eligible for participation in P4P. There was consensus that P4P results would be meaningful and motivate improvement for providers with 40 percent or higher Medicaid participation. With this change, 20 facilities not eligible under the one standard deviation cut-off would become eligible.

A facility's Medicaid days are used to determine eligibility for P4P as well as to establish the amount of P4P incentive payment they will receive if they perform well relative to their peers. Medicaid days are captured on the most recent cost report submitted by the facility to Myers and Stauffer LC. The Department sent out facility specific P4P scores in July 2009 and providers began to raise questions as to precisely what days comprise Medicaid days. The workgroup examined how Medicaid days are derived and came to the conclusion that Medicaid hospice days were not being counted in the Medicaid days used for P4P. This was due to how the facilities report days on the actual cost report. The workgroup concluded that Medicaid hospice days should be counted towards a facility's total Medicaid days for purposes of P4P and the Department is working with Myers and Stauffer LC to revise the cost report to capture that information.

When determining eligibility for P4P, the Department not only takes into consideration Medicaid days, whether or not a facility is a CCRC or has fewer than 45 beds, but also examines OHCQ deficiency data. In the original methodology, criteria were set forth by OHCQ which the Department utilized to disqualify facilities from participation in P4P. When the workgroup examined this component of the methodology, it was clear that the time frame for the OHCQ component was vague. HB 782/SB 664 indicates that the Department is to score nursing facilities based on the P4P criteria on or before July 1 of each year and therefore the Department initially decided to collect the OHCQ data in early June to capture the most recent deficiency data. The workgroup felt this was problematic because there is an Informal Dispute Resolution (IDR) process that allows facilities to dispute deficiencies with OHCQ which in turn may take up to 3 months to resolve. The outcome may be that the deficiency is vacated and does not show on the facility's record. Because OHCQ surveys each facility at varying times throughout the year, choosing a time frame that suits all facilities and takes into consideration the IDR process was problematic. The Department met with OHCQ and concluded that the one year period of April 1 through March 31 would be the most appropriate time period for which to look at the deficiency data for all facilities in Maryland and upon which to base disqualifications. This gives facilities with deficiencies in March the opportunity to participate in the IDR process before the Department proceeds with scoring all facilities in mid to late June.

Once it is determined which facilities are eligible, the Department scores all facilities and mails transmittals to them in July of each year. The workgroup felt as though a data review period would be pertinent so as to allow any disputes over scoring to be resolved before final payouts are determined and distributed to each facility. A review period of 30 days, from the date of the transmittal, will allow sufficient time for providers to contact the Department with questions regarding the data. If an error is found in the data, all facilities shall be rescored and new P4P scores will be sent out to facilities. Another review period will be allowed if the rescoring results in significant modifications. Once the review period has ended, the Department will begin distribution of P4P incentive payments.

In July of 2009, providers received their P4P scores via transmittal from the Department. Only eligible facilities received scores and ineligible facilities were told they were ineligible. This presented a problem to the workgroup and to providers because those ineligible facilities wanted to know how they performed and where and how they could improve. Ineligible facilities were not scored because they would alter the rankings of eligible providers, since facilities' scores are based upon how they perform relative to each other. A scoring mechanism was presented to the workgroup that resolved this issue. Eligible facilities would first be scored and ranked relative to other eligible facilities only. Ineligible facilities would then be scored relative to the eligible providers, and their scores would be arrayed among eligible facilities however no payment will be associated with those that are ineligible. By scoring the ineligible and eligible facilities together, everyone will have scores but the scores of the ineligible facilities will not change the score, rank, or payment for eligible providers.

Improvement Methodology

HB 782/SB 664 also indicates that, in performing its review of the P4P program, "the Department shall examine and modify the pay-for-performance program to include improvement measures in the scoring criteria."

The workgroup considered 3 options: most points increase; highest percentage increase; and improvement as measured by an "S" curve that would give greater weight to improvement among mid-range scores compared with those with the lowest or highest points.

Many workgroup members felt that a percentage improvement methodology would give too much recognition to improvement among the lowest-performing facilities. A slight increase in points would represent a big percentage increase for a facility starting out with a low number of points, yet they might remain a relatively low performing facility. The "S" curve is intended to correct for this effect. Point increases would yield greater improvement scores in the middle of the range compared with equivalent point increases among facilities at the top or bottom of the range. This would deemphasize improvement among facilities that continue to be lower performing, and would stress improvement among facilities that are at least in the average range. However, members felt that lower performing facilities that were making significant strides should be recognized,

encouraged, and rewarded, even if they still had far to go. Ultimately, it was decided that recognizing the facilities with the greatest point increases in their P4P scores, regardless of where they fell on the continuum, was most consistent with the pay-for-improvement objective.

In order to be eligible for pay-for-improvement, a facility must be eligible for P4P during both years that are being compared, and not receiving a P4P payout based upon scoring within the top 35 percent.

Under the current model, approximately $6.5 million will be distributed to the highest scoring facilities. In order to reserve a portion of the funding for those facilities that demonstrate the greatest improvement but are not among the top 35 percent, it is proposed that 85 percent of the funding ($5.5 million) be distributed to the top 35 percent facilities, and that 15 percent of the funding ($1 million) be distributed to the most improved facilities. These facilities could receive between $1 and $2 per day based upon the point increase from the prior year; funds would be distributed among the most improved facilities.

Issues Discussed

During workgroup meetings, it was suggested that there is a relationship between the percentage of Medicaid recipients in a nursing facility and their corresponding P4P scores. It was thought that facilities in more urban areas with a higher Medicaid proportion were disadvantaged by the scoring methodology. When the Department examined the relationship between Medicaid proportion in all facilities in Maryland and their P4P scores, it was found that the higher the percent of Medicaid recipients in a facility, the lower the P4P scores, indicating that these facilities as a group do not perform as well in P4P as those facilities with a lower Medicaid proportion. However, no inherent bias in the measurement criteria or scoring methodology was identified that would disadvantage urban facilities or those with a higher Medicaid proportion. Anecdotally, one of the highest performing facilities has a Medicaid proportion of 90 percent.

The Department also analyzed the relationship between profit in nursing in each facility and their P4P scores. The data indicated a negative relationship where, as the amount of profit in nursing goes up in a facility, the P4P scores go down, meaning that facilities that did not spend the full amount of the Medicaid rate for nursing services had lower performance scores. Notably, the correlation between spending and performance was stronger than that between Medicaid proportion and performance. In fact, lower spending on nursing services may partially explain the lower performance among higher Medicaid facilities since many of the higher Medicaid proportion facilities tend to realize more profit in nursing.

Distribution of Funds

The composite score will indicate each facility's rank and amount of payment per Medicaid patient day. The current model shows the highest scoring facilities, representing 35 percent of the eligible days of care, receiving a quality incentive payment per Medicaid patient day. The amount of quality incentive payment is contingent upon several factors. This year the change in the cutoff for eligibility from one standard deviation to 40 percent, lower revenue from the quality assessment, and the carve-out of improvement funds will increase the number of providers eligible for P4P and decrease the amount of incentive payments available per Medicaid patient day.

In accordance with SB 101, up to 25 percent of the revenues generated by the nursing facility quality assessment shall be used as an incentive payment based on measures that indicate quality of care or a commitment to quality of care. In FY 2010, the amount of rate increase funded by the quality assessment totals approximately $29.2 million. The funding for P4P will be derived from a re-allocation of a portion of the rate increase funded by the quality assessment. By reducing the average facility reimbursement by one-half of 1 percent, approximately $6.5 million (total funds) would have been available for P4P implementation in FY 2010.

Next Steps

The Department will promulgate regulations and amend the Medicaid State Plan to reflect the revised P4P eligibility criteria.

All facilities will be rescored according to the revised model based upon FY 2010 data in order to enable the Department to determine qualification for payment for improvement in FY 2011.

Appendix A: List of P4P Workgroup Members

Organization
Hilltop Institute, UMBC
Health Facilities Association of Maryland
LifeSpan Network
Service Employees International Union (SEIU)-1199
Secretary's Quality Council, DHMH
Maryland Health Care Commission
Voices for Quality Care
Alzheimer's Association
Myers and Stauffer LC
Office of Health Care Quality
Maryland Office of Epidemiology and Disease Control Programs
Medicaid Program Staff

Appendix B

NAME	Rank	Staff	MHCC	MDS	ICP/Flu*	Total Score	$/MA Day	Total $'s
EGLE NURSING HOME	1	33.9	38.9	11.1	2.0	85.8	$6.40	$136,026
COFFMAN NURSING HOME	2	32.4	33.8	12.6		78.7	$5.66	$75,312
COLLINGSWOOD NURSING AND REHAB CENTER	3	32.6	31.2	11.7	2.0	77.5	$5.53	$202,713
DENNETT ROAD MANOR	4	33.6	30.4	10.0	2.0	75.9	$5.37	$160,010
ST. CATHERINE'S NURSING CENTER	5	25.8	38.6	11.4		75.8	$5.36	$75,480
CAROLINE NURSING HOME	6	27.7	33.2	12.6	1.0	74.5	$5.22	$114,720
HEBREW HOME OF GREATER WASHINGTON	7	33.7	29.0	11.8		74.5	$5.22	$653,549
CITIZENS NURSING HOME OF HARFORD CNTY	8	31.5	30.3	12.5		74.4	$5.21	$227,406
GOOD SAMARITAN NURSING CENTER	9	31.6	27.7	11.9	2.0	73.2	$5.08	$161,661
ST. VINCENT CARE CENTER	10	40.0	20.0	11.8	1.0	72.8	$5.05	$69,533
WILLIAMSPORT NURSING HOME	11	30.0	28.9	12.9		71.7	$4.93	$114,208
ALTHEA WOODLAND NURSING HOME	12	26.2	32.3	12.7		71.3	$4.88	$70,755
OAKLAND NURSING AND REHAB	13	28.8	29.0	10.8	2.0	70.7	$4.82	$115,916
LEVINDALE HEBREW GERIATRIC CENTER	14	34.4	24.8	8.9	2.0	70.2	$4.77	$206,546
STELLA MARIS	15	30.3	26.1	12.0		68.4	$4.59	$394,579
KESWICK MULTICARE CENTER	16	32.5	28.5	6.6		67.6	$4.50	$241,187
ALICE BYRD TAWES NURSING HOME	17	31.3	24.6	9.1	2.0	67.0	$4.44	$86,189
LORIEN NURSING & REHAB CENTER MT. AIRY	18	18.6	34.4	11.5	2.0	66.6	$4.39	$51,956
SALISBURY REHAB & NURSING CENTER	19	35.3	19.5	10.6	1.0	66.4	$4.37	$313,928
FROSTBURG NURSING AND REHAB CENTER	20	23.8	29.6	10.8	2.0	66.2	$4.36	$101,671
HARTLEY HALL NURSING HOME	21	21.0	31.6	10.7	2.0	65.3	$4.26	$59,904
JOHNS HOPKINS BAYVIEW CARE CENTER	22	37.7	12.9	10.6	4.0	65.3	$4.26	$131,498
THE PINES	23	31.1	26.4	7.3		64.8	$4.21	$155,294
SACRED HEART HOME	24	12.9	36.3	15.5		64.7	$4.20	$97,877
CHESAPEAKE WOODS CENTER	25	27.5	21.2	13.2	2.0	63.9	$4.12	$91,732
PLEASANT VIEW NURSING HOME OF MT. AIRY	26	23.9	29.3	10.6		63.8	$4.11	$122,367
MILFORD MANOR NURSING HOME	27	32.0	21.3	9.8		63.0	$4.03	$108,754
CHARLOTTE HALL VETERANS HOME	28	19.3	26.7	12.4	4.0	62.4	$3.96	$204,340
WICOMICO NURSING HOME	29	22.1	29.5	10.1		61.7	$3.89	$89,229
ST. ELIZABETH REHAB & NURSING CENTER	30	24.7	26.7	8.0	2.0	61.4	$3.85	$140,972
SNOW HILL NURSING & REHAB CENTER	31	25.3	25.9	10.0		61.2	$3.83	$60,395
RIDGEWAY MANOR NURSING & REHAB CNTR	32	26.6	22.8	10.3	1.0	60.7	$3.78	$47,995
CATONSVILLE COMMONS	33	33.0	18.6	9.0		60.6	$3.77	$133,873
RANDOLPH HILLS NURSING HOME	34	31.5	17.7	11.1		60.4	$3.75	$113,610
MANOKIN MANOR NURSING & REHAB CENTER	35	23.3	27.6	8.7		59.6	$3.67	$123,536
BRADFORD OAKS NRSING & RETIREMENT CNTR	36	18.3	23.3	15.4	2.0	59.0	$3.61	$165,360
FROSTBURG VILLAGE NURSING CARE CENTER	37	21.2	28.3	8.4	1.0	58.9	$3.59	$101,723

CALVERT COUNTY NURSING CENTER	38	18.9	26.8	10.6	2.0	58.4	$3.54	$101,966
SLIGO CREEK NURSNG AND REHAB CENTER	39	22.4	21.2	12.4	2.0	58.0	$3.50	$80,052
BETHESDA HEALTH AND REHAB CENTER	40	29.5	21.5	6.7		57.8	$3.48	$131,561
MAGNOLIA CENTER	41	28.5	21.6	6.5	1.0	57.7	$3.47	$79,505
JEWISH CONVALESCENT & NURSING HOME	42	29.5	21.5	5.7	1.0	57.6	$3.46	$123,868
CITIZENS NURSING HOME OF FREDERICK CNTY	43	24.2	22.8	10.6		57.6	$3.46	$133,553
FORT WASHINGTON HEALTH AND REHAB CENTER	44	27.3	17.3	12.8		57.4	$3.43	$39,363
MORAN MANOR	45	15.7	29.5	12.1		57.3	$3.43	$105,658
ARCOLA HEALTH AND REHABILITATION CENTER	46	22.3	25.3	9.4		57.0	$3.40	$122,012
CRESCENT CITIES CENTER	47	29.9	16.9	8.1	2.0	56.8		$0
VINDOBONA NURSING HOME	48	17.0	29.6	9.6		56.2		$0
RUXTON HEALTH OF PIKESVILLE	49	25.1	21.5	9.5		56.1		$0
CHARLES COUNTY NURSING & REHAB CENTER	50	17.5	27.9	9.2	1.0	55.6		$0
LIONS MANOR NURSING HOME	51	15.1	31.6	8.7		55.4		$0
GOLDEN LIVING CENTER - CUMBERLAND	52	14.0	27.7	13.6		55.3		$0
WALDORF CENTER	53	24.7	15.7	13.7	1.0	55.1		$0
WOODSIDE CENTER	54	27.7	16.4	8.9	2.0	55.0		$0
VILLA ROSA NURSING HOME	55	19.5	23.3	12.2		55.0		$0
ST. MARY'S NURSING CENTER INC.	56	14.5	26.1	10.0	4.0	54.6		$0
HAMILTON CENTER	57	26.5	21.9	2.6	2.0	53.0		$0
FUTURECARE SANDTOWN-WINCHESTER	58	32.6	13.7	5.6	1.0	52.9		$0
SOUTH RIVER HEALTH AND REHAB CTR.	59	18.0	20.5	13.1	1.0	52.6		$0
PINEVIEW NURSING & REHABILITATION CENTRE	60	22.4	21.3	6.9	2.0	52.6		$0
LORIEN NURSING & REHAB CENTER RIVERSIDE	61	17.8	24.4	9.3	1.0	52.5		$0
FREDERICK VILLA NURSING CENTER	62	16.0	22.6	12.5	1.0	52.1		$0
ARLINGTON WEST NRSING AND REHAB CENTER	63	19.9	20.0	12.1		51.9		$0
BERLIN NURSING AND REHABILITATION CENTER	64	21.2	18.3	10.4	2.0	51.9		$0
FORESTVILLE HEALTH AND REHAB CENTER	65	21.7	15.6	14.6		51.9		$0
ENVOY OF DENTON	66	15.5	25.3	11.2		51.9		$0
CATON MANOR	67	30.2	13.5	7.8		51.6		$0
SUNBRIDGE CARE AND REHAB FOR ELKTON	68	20.5	20.3	10.5		51.3		$0
APEX HEALTH OF SILVER SPRING	69	16.3	22.1	12.8		51.2		$0
SOLOMON'S NURSING CENTER	70	14.3	25.6	10.0	1.0	50.9		$0
FOREST HAVEN NURSING HOME	71	27.6	11.3	11.7		50.5		$0
BRINTON WOODS NURSING & REHAB CTR	72	12.1	26.4	12.0		50.5		$0
HOMEWOOD CENTER	73	22.3	20.0	7.9		50.2		$0
HERITAGE CENTER	74	25.4	14.7	8.0	2.0	50.1		$0
OVERLEA HEALTH AND REHAB CENTER	75	22.1	17.5	9.1	1.0	49.7		$0
MULTI-MEDICAL CENTER	76	21.9	20.7	4.8	2.0	49.5		$0

ALLEGANY COUNTY NURSING HOME	77	10.3	27.5	11.3		49.0	$0
MANORCARE HEALTH SERVICES RUXTON	78	25.9	17.1	4.9	1.0	48.9	$0
KNOLLWOOD MANOR NURSING HOME	79	21.9	17.6	9.0		48.5	$0
HEARTLAND HEALTH CARE CNTR - HYATTSVILLE	80	23.6	18.3	6.4		48.4	$0
DEVLIN MANOR NURSING HOME	81	9.6	27.3	9.0	2.0	48.0	$0
FUTURECARE CANTON HARBOR	82	19.5	19.0	7.4	2.0	47.9	$0
RANDALLSTOWN CENTER	83	31.1	8.4	7.3	1.0	47.8	$0
MID-ATLANTIC OF FAIRFIELD	84	9.2	27.5	9.7		46.4	$0
CORSICA HILLS CENTER	85	24.3	13.7	8.0		46.0	$0
BEL AIR HEALTH AND REHABILITATION CENTER	86	26.3	11.5	8.0		45.8	$0
LORIEN NURSING & REHAB CENTER COLUMBIA	87	12.1	22.7	9.5	1.0	45.3	$0
FAIRLAND NURSING & REHAB CENTER	88	19.7	13.8	10.5	1.0	45.1	$0
GLEN BURNIE HEALTH AND REHAB CENTER	89	10.6	27.5	6.9		45.0	$0
FRANKFORD NURSING & REHAB CENTER	90	21.9	15.3	7.2		44.3	$0
LA PLATA CENTER	91	22.1	16.7	5.2		44.0	$0
PERRING PARKWAY CENTER	92	27.1	7.9	8.1		43.0	$0
SIGNATURE HEALTHCARE AT MALLARD BAY	93	16.6	21.4	4.7		42.7	$0
CHESAPEAKE SHORES	94	23.1	14.8	4.7		42.6	$0
GLADYS SPELLMAN HSPITAL & NRSNG CENTER	95	13.1	17.8	9.6	2.0	42.5	$0
FUTURECARE CHESAPEAKE	96	20.9	11.0	8.5	2.0	42.4	$0
FUTURECARE HOMEWOOD	97	17.9	15.9	6.2	2.0	42.0	$0
FUTURECARE OLD COURT	98	20.0	14.0	5.2	2.0	41.2	$0
RIVERVIEW CARE CENTER LLC	99	8.6	22.5	9.9		41.0	$0
FOREST HILL HEALTH AND REHAB CENTER	100	10.7	19.9	9.2	1.0	40.8	$0
TRANSITIONS HEALTHCARE AT SYKESVILLE	101	10.0	20.0	6.2	4.0	40.3	$0
COLLEGE VIEW CENTER	102	19.4	11.5	7.1	2.0	40.0	$0
CHESTER RIVER MANOR	103	0.9	27.0	11.6		39.5	$0
LONG GREEN CENTER	104	21.4	8.9	8.8		39.1	$0
IVY HALL GERIATRIC CENTER	105	9.4	19.6	10.0		39.0	$0
LOCH RAVEN CENTER	106	27.1	7.1	3.6	1.0	38.7	$0
MARLEY NECK HEALTH & REHAB CTR.	107	15.9	10.9	11.6		38.4	$0
FUTURECARE CHERRYWOOD	108	7.2	19.8	7.2	4.0	38.1	$0
BLUE POINT NURSING CENTER	109	16.7	9.9	11.3		37.9	$0
LARKIN CHASE NRSING & RESTORATIVE CNTR	110	5.3	24.3	8.1		37.8	$0
SUMMIT PARK HEALTH AND REHAB CENTER	111	11.4	19.2	6.1	1.0	37.7	$0
LAYHILL CENTER	112	26.3	4.6	5.8	1.0	37.7	$0
GREATER LAUREL HEALTH AND REHAB CENTER	113	10.8	19.5	5.2	2.0	37.4	$0
MANORCARE HEALTH SERVICES SILVER SPRING	114	17.7	13.9	4.8	1.0	37.4	$0
MANORCARE HEALTH SERVICES TOWSON	115	18.5	10.0	8.7		37.3	$0
CHAPEL HILL NURSING CENTER	116	0.0	25.4	11.7		37.0	$0

LOCHEARN NURSING HOME	117	16.6	13.4	5.8	1.0	36.8	$0
FAYETTE HEALTH AND REHAB CTR	118	19.3	8.3	8.8		36.4	$0
KENSINGTON NRSNG AND REHAB CENTER	119	15.1	13.6	7.7		36.4	$0
MANORCARE HEALTH SERVICES LARGO	120	9.5	17.4	9.5		36.3	$0
ELLICOTT CITY HEALTH AND REHAB CENTER	121	21.9	5.3	6.6	2.0	35.9	$0
ALICE MANOR NURSING HOME	122	8.0	20.2	7.2		35.4	$0
REEDERS MEMORIAL HOME	123	6.6	19.7	8.8		35.1	$0
SPRINGBRK. ADVENTIST NURSING & REHAB CNTR	124	9.3	11.7	12.2	1.0	34.1	$0
NORTHWEST HEALTH & REHAB CTR.	125	15.5	6.4	11.6		33.4	$0
MANORCARE HEALTH SERVICES WHEATON	126	14.0	6.4	12.6		33.1	$0
NORTH ARUNDEL HEALTH AND REHAB CENTER	127	9.3	15.5	8.2		33.0	$0
GOLDEN LIVING CENTER - WESTMINSTER	128	0.5	19.1	13.3		32.9	$0
ANNAPOLIS NURSING & REHABILITATION CENTER	129	20.0	3.1	8.2	1.0	32.3	$0
HOLLY HILL MANOR INC	130	10.1	14.5	7.7		32.2	$0
GOLDEN LIVING CENTER - HAGERSTOWN	131	9.1	10.7	12.4	0.0	32.1	$0
JULIA MANOR HEALTH CARE CENTER	132	6.7	15.4	9.8		32.0	$0
LIBERTY HEIGHTS HEALTH & REHAB CTR.	133	10.8	7.7	12.7		31.2	$0
CHERRY LANE NURSING CENTER	134	11.4	11.6	7.6		30.6	$0
LAURELWOOD CARE CENTER AT ELKTON	135	1.9	20.0	8.5		30.3	$0
FUTURE CARE NORTHPOINT	136	0.9	17.4	10.6	1.0	29.8	$0
FUTURECARE IRVINGTON	137	13.7	8.6	5.3	1.0	28.6	$0
MANORCARE OF DULANEY	138	9.6	10.0	8.5		28.1	$0
HEARTLAND HEALTH CARE CENTER - ADELPHI	139	6.2	7.4	11.5	2.0	27.2	$0
FUTURE CARE CHARLES VILLAGE	140	10.3	7.5	4.6	2.0	24.5	$0
MANORCARE HEALTH SERVICES ROLAND PARK	141	10.6	5.3	6.2	2.0	24.0	$0
HARBORSIDE HEALTHCARE - HARFORD GARDENS	142	1.8	10.7	9.2		21.6	$0
CLINTON NURSING AND REHABILITATION CENTER	143	8.5	7.8	5.1		21.4	$0
ROCK GLEN NURSING AND REHAB CENTER	144	0.0	8.0	9.2		17.2	$0

* empty field indicates that we did not receive data from this facility