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516th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
February 11, 2015

EXECUTIVE SESSION
12:00 p.m.

(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

1. **Status of Medicare Data Submission and Reconciliation – Authority General Provisions Article, § 3-104**
2. **Contract and Modeling of the All-payer Model and Legal Consultation on Potential Alternate Medicare Payment for Hospital Services vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, § 3-104, and 3-305**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on January 14, 2014**
2. **Executive Director's Report**
3. **New Model Monitoring**
4. **Docket Status – Cases Closed**

   2265A – Holy Cross Hospital
   2282A – University of Maryland Medical Center
   2283A - Johns Hopkins Health System
   2286A - Johns Hopkins Health System

5. **Docket Status – Cases Open**

   2284R – Garrett County Memorial Hospital
   2285R - Johns Hopkins Bayview Medical Center
   2287A- University of Maryland Medical Center
   2288R - MedStar Southern Maryland Hospital Center
   2289 – MedStar Franklin Square Hospital Center

6. **VHQC (Medicare Quality Improvement Organization) Presentation on Maryland Readmission Data**
7. **Draft Recommendation for Modifications to the Readmission Reduction Incentive Program for FY 2017**
8. **Draft Recommendations for Total Amount at Risk for Quality Programs for FY 2017**
9. **Work Group Updates**

10. **Legislative Report**

11. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

January 14, 2015

Upon motion made in public session, Chairman Colmers call for adjournment into closed session to discuss the following item:

1. Status of Medicare Data Submission and Reconciliation.

The Closed Session was called to order at 12:33 p.m. and held under authority of Section 3-104 of the General Provisions Article.

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, Loftus, Mullen, and Wong.

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, Sule Calikoglu, Jerry Schmith, and Chris O'Brien.

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

David Romans, Director-Payment Reform and Innovation, presented an updated analysis of Medicare per beneficiary data. Authority: General Provisions Article, § 3-104.

Closed Session was adjourned at 12:56 p.m.

Executive Director's Report

Health Services Cost Review Commission

February 11, 2015

National Update

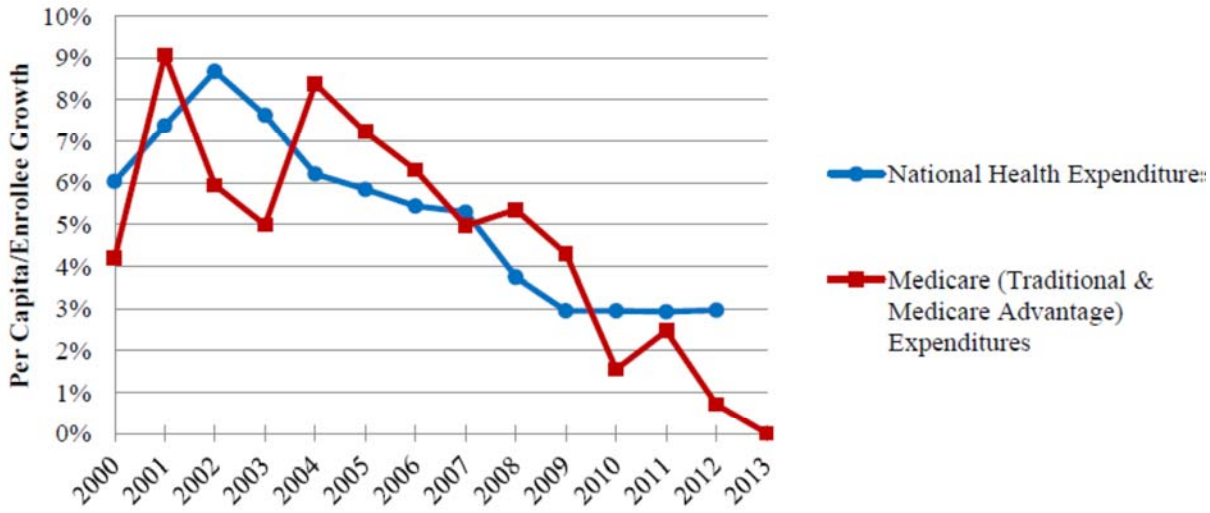
There are a number of national initiatives and trends that could augment or accelerate Maryland's All-Payer Model that started January 1, 2014. Some of these national initiatives involve providers outside of HSCRC's regulatory authority, but are directly related to the partnership work groups that HSCRC has initiated together with other State agencies and stakeholders. This is an especially critical time, when collective approaches could accelerate progress in improving patient care and assist in modernizing delivery models.

National Spending

*Source: aspe.hhs.gov/health/reports/2014/**MedicareCost**/ib_medi**cost**.pdf*

The rate of national health care spending growth per person has been on a downward trajectory in recent years (see Figure 1). This downward trend has been especially significant for the Medicare program since 2009. In fact, the most recent data show that the average per enrollee annual spending growth rate for the Medicare program (including both Traditional Medicare and the Medicare Advantage (MA) program) for 2009-2012 was one-third of the average growth rate from 2000-2008: 2.3 percent versus 6.3 percent (data not shown in table). The per enrollee expenditure growth rate for Medicare in 2013 was only 0.1 percent. Early claims data as well as Treasury data on Medicare payments from the first half of 2014 indicate that very slow per capita growth has continued, although final spending growth estimates will not be available for some time. Reductions in spending growth for acute inpatient and post-acute care services accounted for half of the overall slowdown in spending growth.

Figure 1
Per Capita/Enrollee Spending Growth Rates for National Health Expenditures and Medicare, 2000-2012



Data Source: 2000-2012 data from CMS National Health Expenditure Accounts, preliminary 2013 Medicare per enrollee spending growth rate estimate from Centers for Medicare and Medicaid Services Office of the Actuary.

Note: Growth rate for 2006 only includes Parts A and B to avoid artificially high growth from introduction of the Part D program.

New Medicare spending projections for 2015 and beyond will be available in the near future from the Office of the Actuary.

Under the All Payer Model, Maryland must produce savings relative to the national growth rate of $330 million over the 5 year period ending December 31, 2018. This equates to about 1/2 percent per year below the national rate of increase. With a declining rate of increase in cost per beneficiary, Maryland needs to be prepared to scale up and rapidly implement care models that assure that we can meet these savings requirements.

HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

On January 26, Health and Human Services Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they render to patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all

traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments. To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network. HHS also plans to work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. HHS will intensify its work with states and private payers to support adoption of alternative payments models.

The Center for Medicare & Medicaid Innovation (CMMI) and HSCRC staff have been discussing Maryland's partnership strategies for Care Coordination and Infrastructure and Alignment on monthly basis. While Maryland is initially ahead of the timelines in implementation, we will need to focus on partnership strategies to ensure that we continue to stay ahead of the requirements, in light of the Medicare savings requirements as well as the "guardrail" requirements relative to total cost of care.

- Nearly all of Maryland hospitals' revenues are now under an alternative payment model with the implementation of the new All-Payer Model effective January 1, 2014.
- For Medicare, an estimated 200,000 to 250,000 of our Medicare beneficiaries are attributed to ACOs--between 1/4 and 1/3 of the beneficiaries.
- Commercial carriers in Maryland have implemented value based models. For example, over 80 percent of all primary care providers in the CareFirst network participate in its Patient Centered Medical Home (PCMH), which covered approximately 1.1 million CareFirst enrollees in 2013. The PCMH model tracks cost and quality for participating practices on a per capita bases, and shares savings through fee increases when quality requirements are met. As an integrated system, Kaiser Permanente's payment and delivery model in Maryland for its physician providers relies on salary models, which are not volume based. These are examples of the growing number of commercial models in Maryland.
- DHMH received a grant from CMMI of $2.5 million to develop the parameters for a Medicaid ACO model for dual eligibles. Most Medicaid enrollees, including the expansion enrollees, are under Managed Care Organization (MCO) arrangements that are capitated with the State.
- The work of the care coordination and infrastructure and alignment work groups will be crucial in recommending strategies that will move progress forward in Maryland.
- CRISP, MHCC, and MedChi worked together to submit a grant request to CMMI to participate in the Transforming Clinical Practice Initiative, which will invest up to $800 million nationally in providing hands-on support to 150,000 physicians and other

clinicians for developing the skills and tools needed to improve care delivery and transition to alternative payment models. Several health systems in Maryland may also have submitted grant requests for this funding.

For more information regarding the HHS initiatives, see:

http://www.nejm.org/doi/full/10.1056/NEJMp1500445

Chronic care management fee

Effective January 1, 2015, Medicare made the most significant change ever to primary care payment when it introduced a non-visit-based payment for chronic care management (CCM). This change has the potential to align efforts of Medicare with the Patient Centered Medical Home model that has been widely adopted in Maryland. It also has significant implications for Maryland by providing a vehicle to better align primary care efforts and hospitals around the opportunity to improve chronic care and to reduce hospitalizations.

According to the New England Journal of Medicine, "Many efforts to reform U.S. health care delivery focus on creating a high-performing primary care system that improves value through increased emphasis on access, prevention, and care coordination. Reformers recognize that the fee-for-service system, which restricts payments for primary care to office-based visits, is poorly designed to support the core activities of primary care, which involve substantial time outside office visits for tasks such as care coordination, patient communication, medication refills, and care provided electronically or by telephone. But this system is about to change." In 2015, a CCM fee of approximately $40 per month is available for practices caring for beneficiaries with two or more chronic conditions that are expected to last at least 12 months and that confer a significant risk of death, decompensation, or functional decline (a category that includes more than two thirds of Medicare beneficiaries). A physician caring for 200 qualifying patients could see additional revenue of roughly $100,000 annually.

To bill for this fee, practices are required to use a certified electronic health record (EHR), offer round-the-clock access to staff who have access to the EHR, maintain a designated practitioner for each patient, and coordinate care through transitions to and from the hospital, specialists, or other providers. The most substantial additional requirement involves collaboration with the patient on creating and maintaining a comprehensive care plan that includes elements such as a list of health issues, medication-management instructions, and a record of involved social and community services, though the exact specifications for such plans have not been released. Practices must obtain patients' consent at least annually to serve as their chronic care provider, and a practice team member must spend at least 20 minutes per month performing non–visit-based care coordination activities for each patient.

The CCM payment's structure and requirements are similar to those of patient-centered medical home (PCMH) initiatives, which generally offer an additional per-member-per-month sum to primary care practices for providing enhanced services. The $40 monthly CCM payment is substantially more than most PCMH initiatives offer but is available only for patients with two or more chronic diseases. Practices need not be formally recognized as PCMHs to receive the payment and so can avoid a costly, time-consuming process.

For more information regarding the new chronic care management fee, see:

http://www.nejm.org/doi/full/10.1056/NEJMp1410790

Flu Update

Situation

Staff reported in the January Commission meeting that there had been an escalation of the flu, beginning in late December 2014. In late December and early January, some hospitals reached maximum staffed occupancy and emergency rooms were crowded and on bypass. HSCRC staff is focused on addressing the potential for impact on global budgets and the Medicare savings requirements of the waiver. Staff is providing an update on the monitoring of flu activities through the end of January 2015. Staff expects to conclude updates at the March Commission meeting. At this point in time, the flu season is usually over.

Analysis

As indicated last month, the HSCRC staff has a number of tools at its disposal to help assess the impact of the flu season. First, the Maryland Department of Health and Mental Hygiene (DHMH) monitors a number of parameters to track influenza. Maryland-specific surveillance data are published weekly in a surveillance report that is available on the DHMH website. DHMH also participates in national surveillance in concert with the Centers for Disease Control and Prevention (CDC), which also tracks and publishes the progression of flu on a weekly basis.

The most recent DHMH surveillance report summary stated the following: “During the week ending January 24, 2015, influenza-like illness (ILI) intensity in Maryland was LOW and there was WIDESPREAD geographic activity. The proportion of outpatient visits for ILI reported by Sentinel Providers rose slightly, while the proportion reported by Maryland Emergency Departments fell. The proportion of specimens testing positive for influenza at clinical laboratories continued to decline. A total of 129 influenza-associated hospitalizations were reported. . . . Nationally, influenza activity remained elevated."

Attached Table 1 obtained from the CDC website shows that the 2014-2015 flu season is tracking 2012-2013. The hospitalization rate for individuals aged 65 and above is the highest in

CDC record keeping, which began in 2005, just above the 2012-2013 period. At present, flu levels are higher in other areas of the U.S. as compared to the levels in Maryland.

Maryland specific Tables 2 and 3 were obtained from DHMH. Table 2 shows that the proportion of emergency room visits attributed to ILI were above base period 2012-2013 levels early in the season but are currently tracking below the 2012-2013 levels. Table 3 shows an early peak in ILI hospitalizations, while current levels are now lower. Next month we will evaluate the final results for 2014-2015 versus the base year 2012-2013.

Conclusion

Flu associated utilization has the potential to impact hospitals' global budgets and Medicare savings. 2013-2014 levels were below the base year levels and hospitals benefited in their global budgets. For the 2014-2015 year, early levels peaked above the 2012-2013 base, but are now lower. HSCRC staff will complete its evaluation of this situation through the end of February. HSCRC encourages hospitals to work with public health officials and affiliated providers to increase anti-influenza vaccine rates in light of the potential for reducing avoidable illness burden, deaths, and costs.

FY 2015 BRFA Planning Grants

As discussed at previous Commission meetings, the 2015 Budget Reconciliation and Financing Act permits the Commission to include up to $15 million in hospital rates to support:

1. Assisting hospitals cover costs associated with implementation of Maryland's all-payer model; and/or
2. Funding of statewide and regional proposals that support the implementation of the all-payer model.

In order to accelerate effective implementation of the new all-payer models, it is important to cultivate regional partnerships throughout the State that can collaborate on analytics, target care coordination and services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. We are inviting and supporting the development of partnerships capable of identifying and addressing their regional needs and priorities and, in turn, shaping the future of health care in Maryland. We expect that proposals will include ways to develop care coordination activities and population health priorities, determining what resources are needed and available, and how resources and strategies should be deployed.

The Department of Health and Mental Hygiene (DHMH) and HSCRC have developed a Request for Proposals (RFP) for up to a total of $2.5 million in regional planning grants to support the development of multi-stakeholder health system transformation partnerships in 5 or more regions in Maryland. The RFP is expected to be released this week and will be made available on the DHMH and HSCRC websites.

CMMI Hospital Site Visits

The CMMI evaluation contractor will begin making site visits to hospitals and other stakeholders over the next few months. CMMI hopes to gain information about the implementation of the All Payer Model and the experiences of each set of stakeholders.

Attachments

Table 1--National CDC tracking of ILI by week

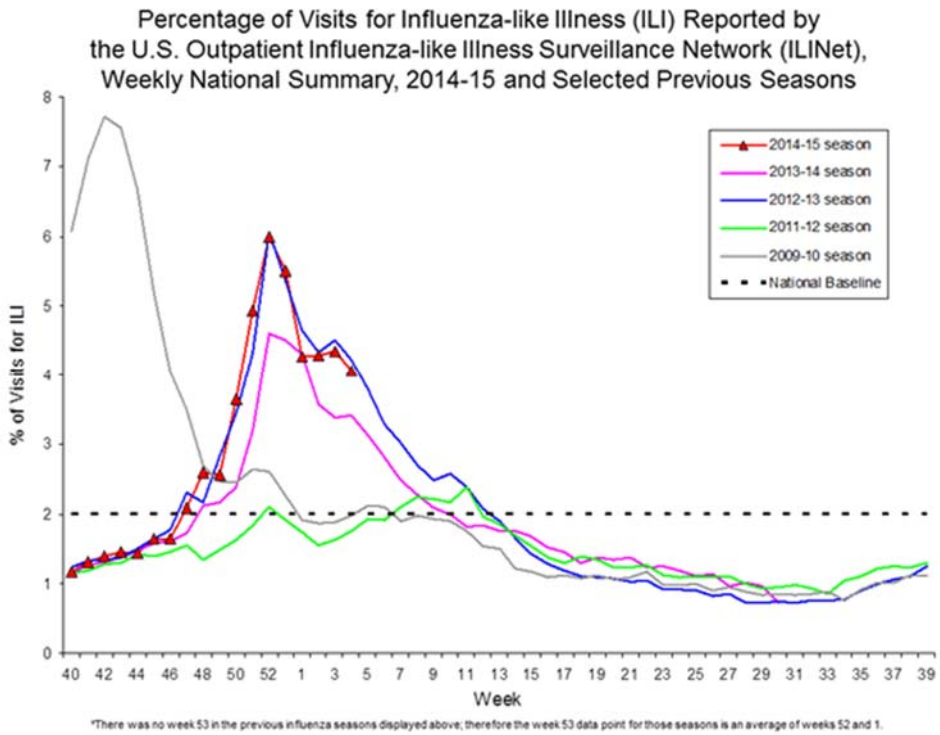


Table 2--DHMH tracking of emergency room visits by week

http://phpa.dhmh.maryland.gov/influenza/fluwatch/Shared%20Documents/Weekly%20Report.pdf

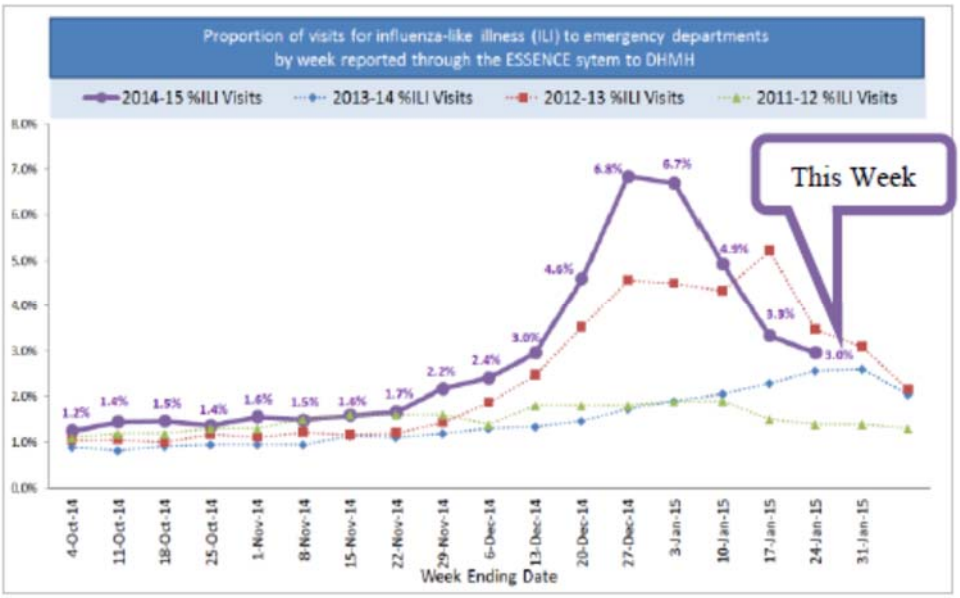
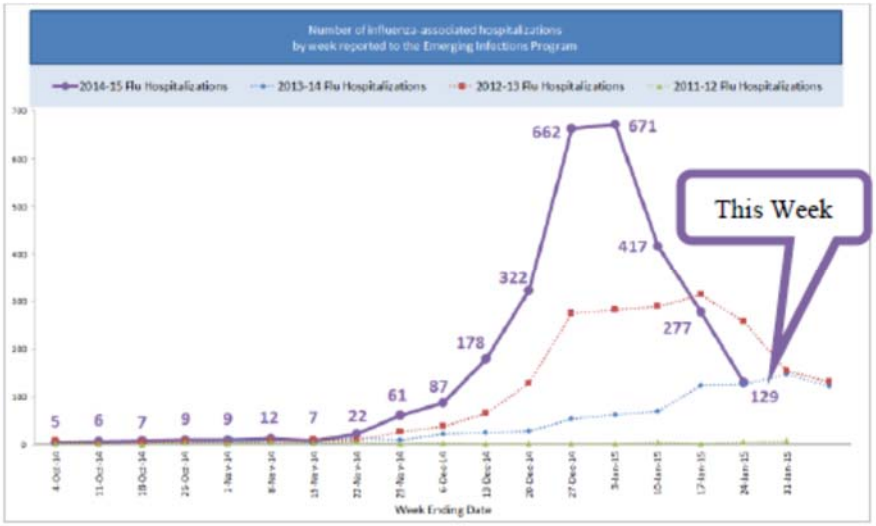
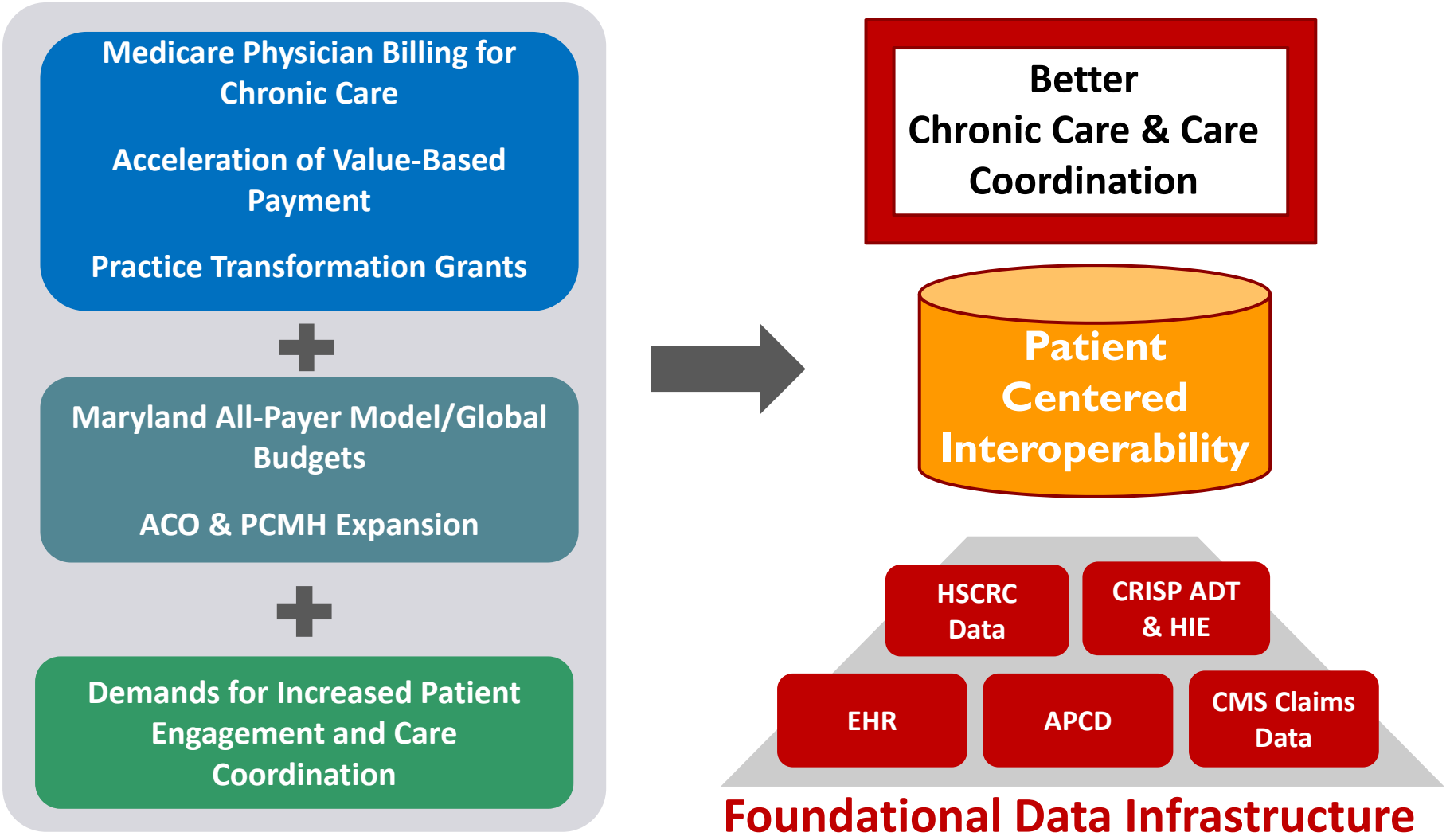


Table 3--DHMH tracking of ILI hospitalizations by week
http://phpa.dhmh.maryland.gov/influenza/fluwatch/Shared%20Documents/Weekly%20Report.pdf



National and Statewide Efforts and Forces are Converging to Support Patient Centered Care in Maryland



Monitoring Maryland Performance

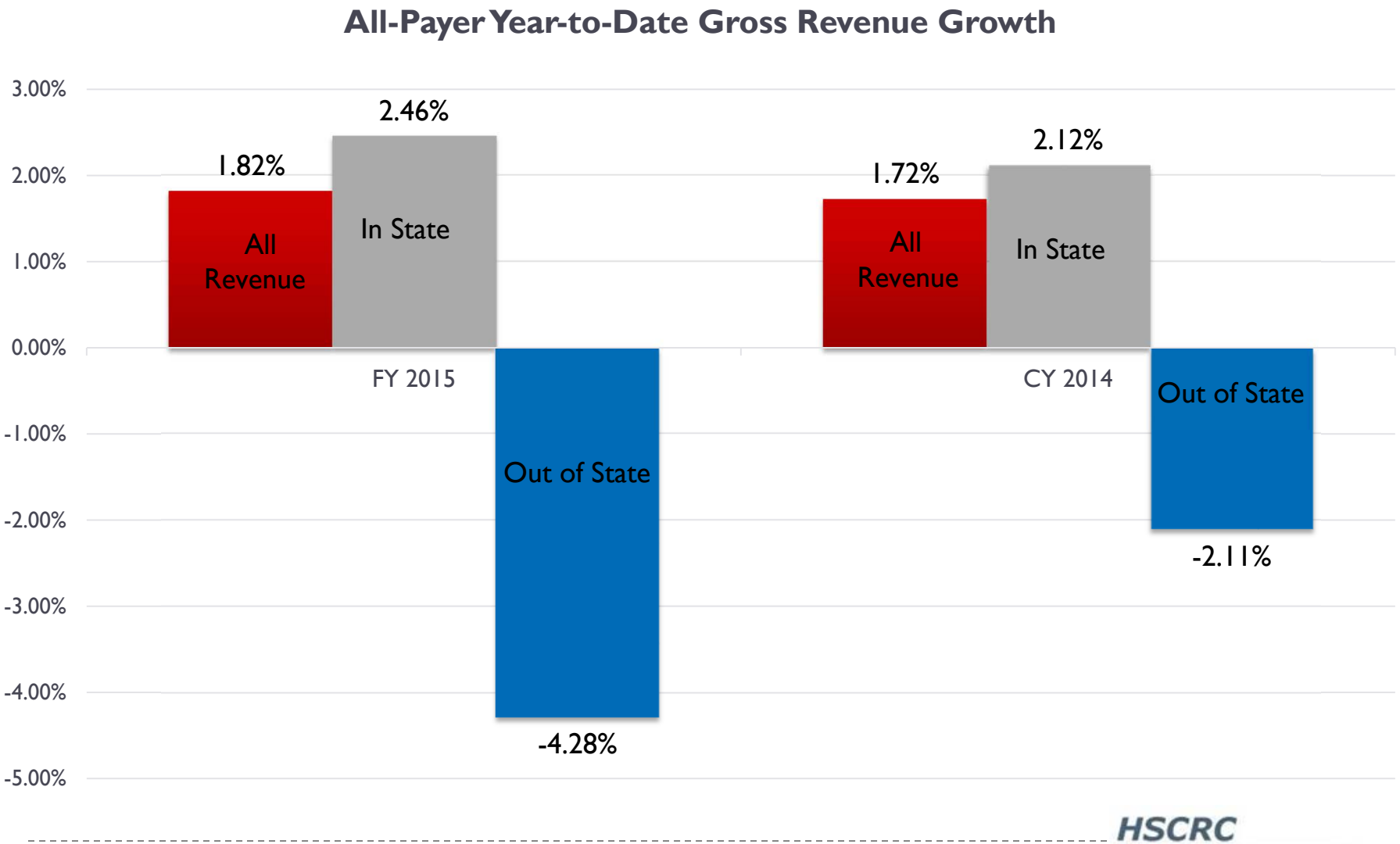
Financial Data

Year to Date thru December 2014

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

Year to Date (thru December 2014) Compared to Same Period in Prior Year



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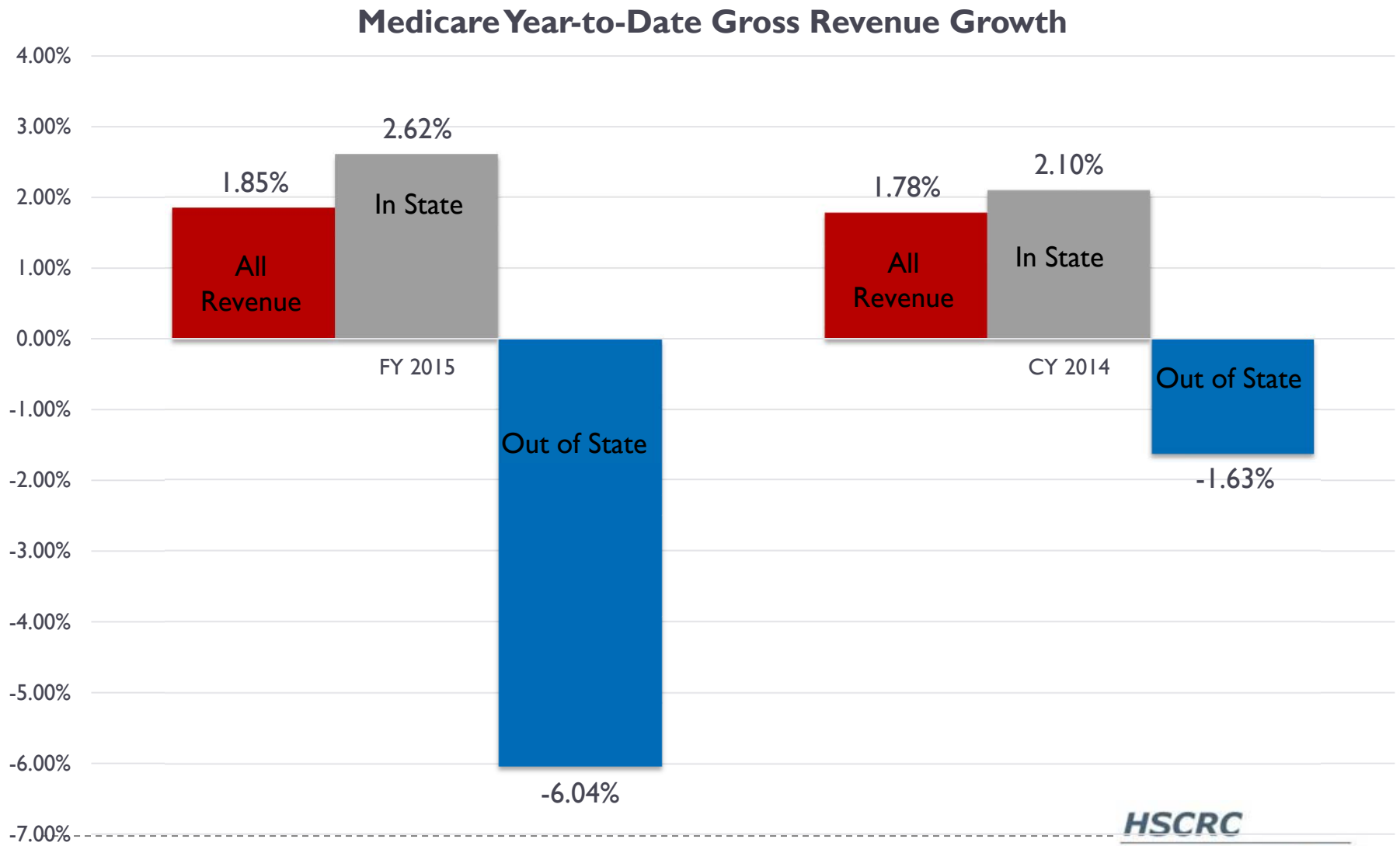
Health Services Cost Review Commission

Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru December 2014) Compared to Same Period in Prior Year



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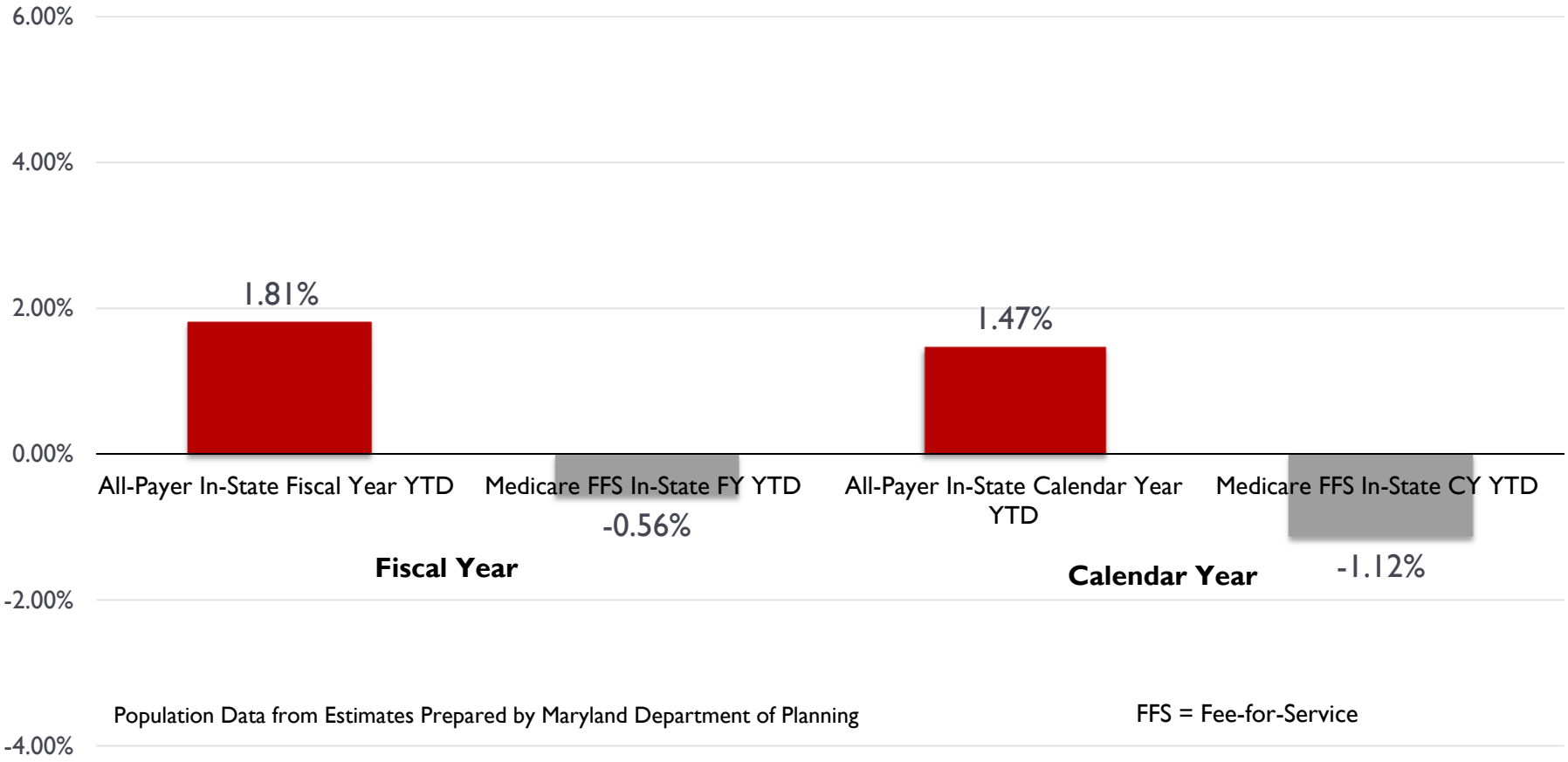
Per Capita Growth Rates
Fiscal Year 2015 and Calendar Year 2014



- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

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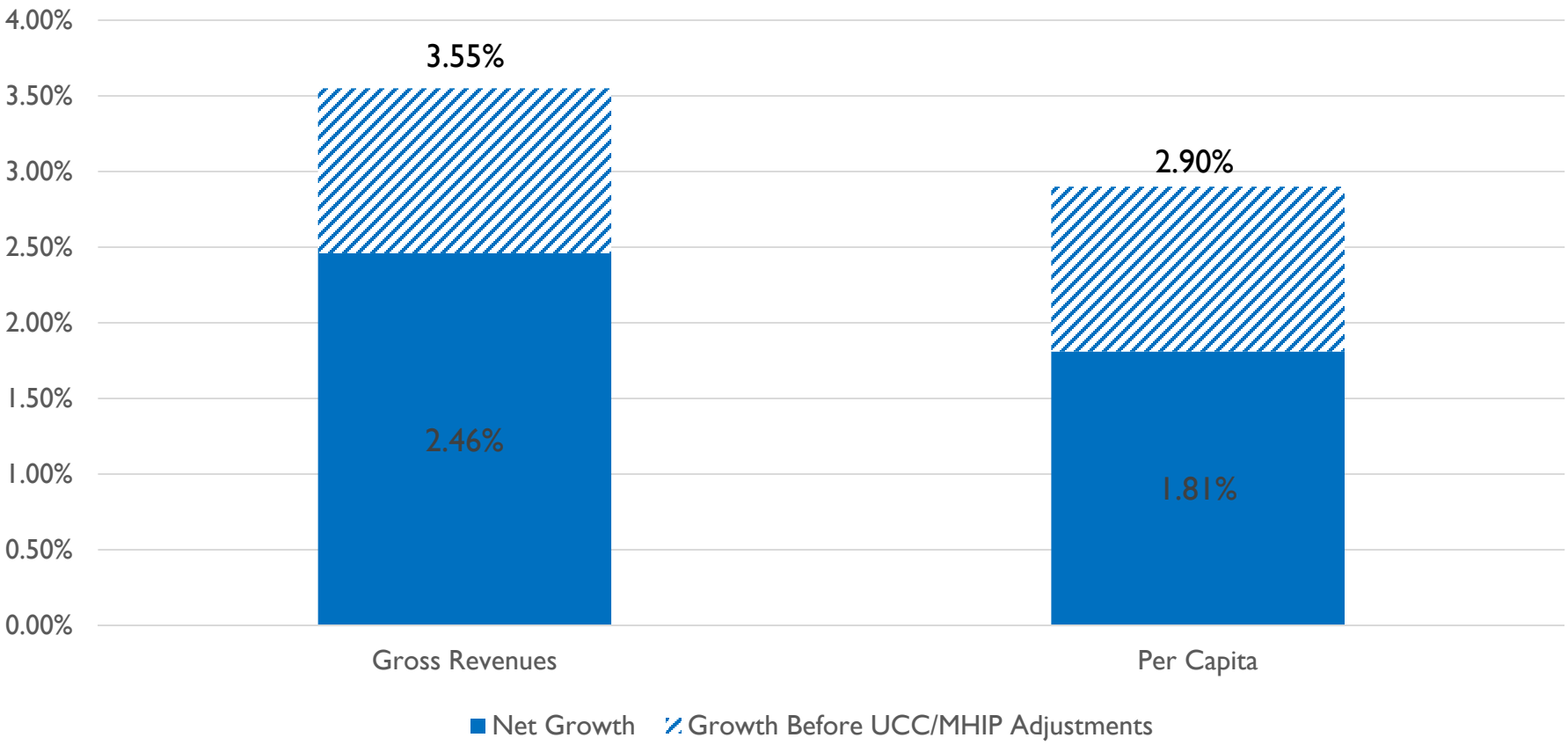
Health Services Cost Review Commission

Underlying Growth in FY 2015 Hospital Revenues
Actual Growth & Effect of Budget Neutral UCC/MHIP Adjustment



- 0.45% revenue decrease offset by reduction in the MHIP assessment paid by hospitals.
- 0.64% UCC revenue decrease offset by reduction in hospital bad debts.

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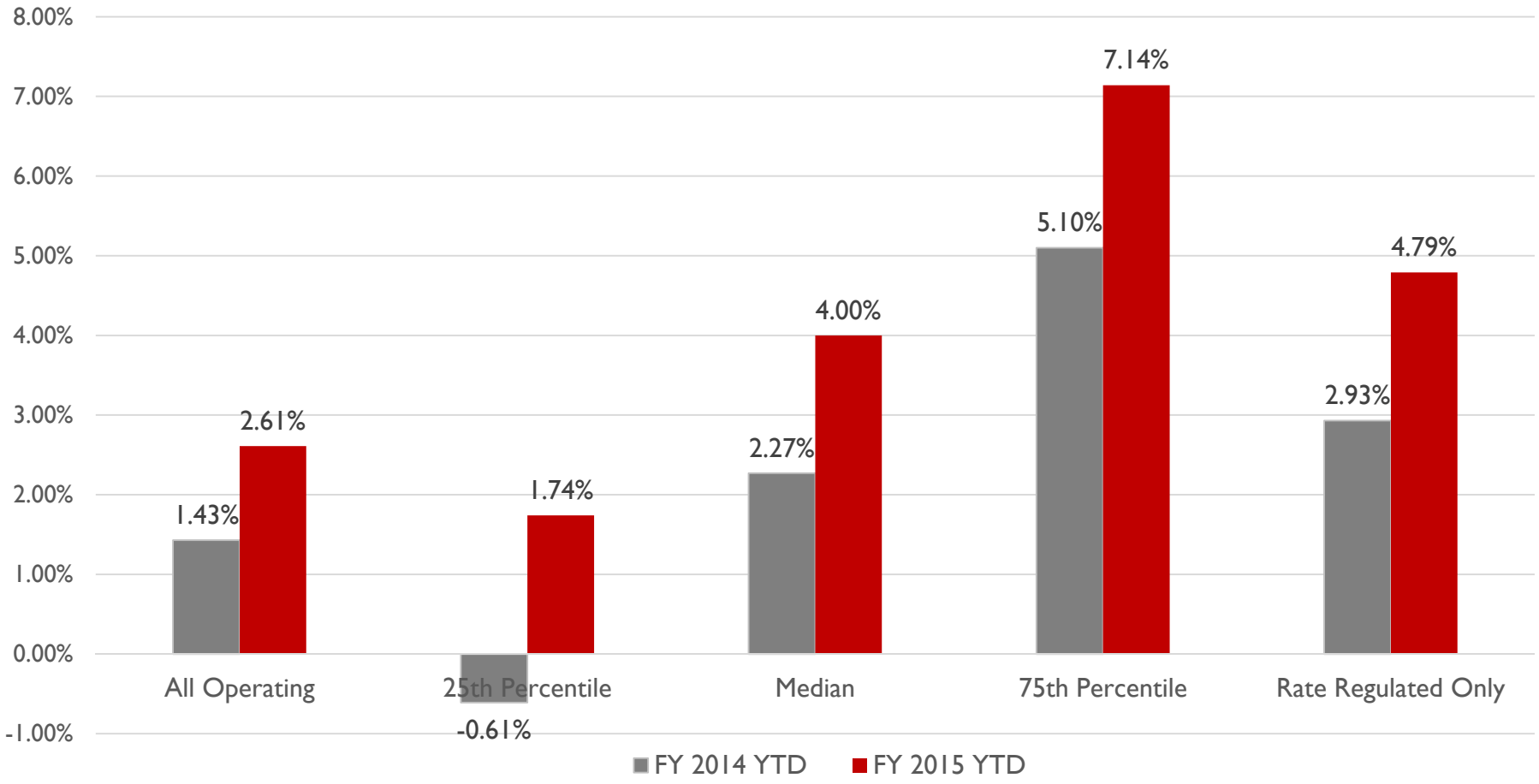
Operating Profits: Fiscal 2015 Year to Date (July-Dec.) Compared to Same Period in FY 2014



- Year-to-Date FY 2015 hospital operating profits improved compared to the same period in FY 2014.

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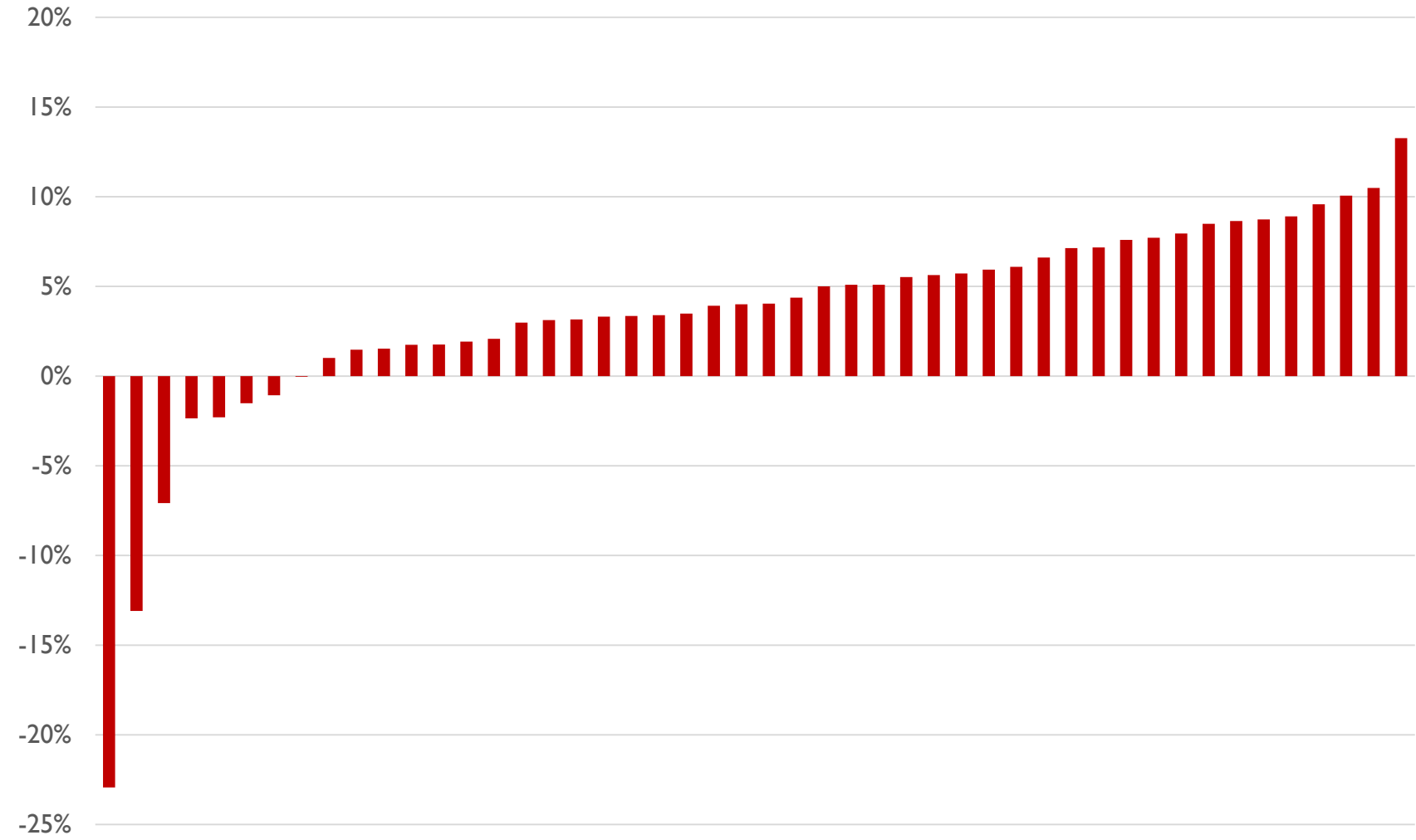
Operating Profits by Hospital

Fiscal Year to Date (July – December)



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Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

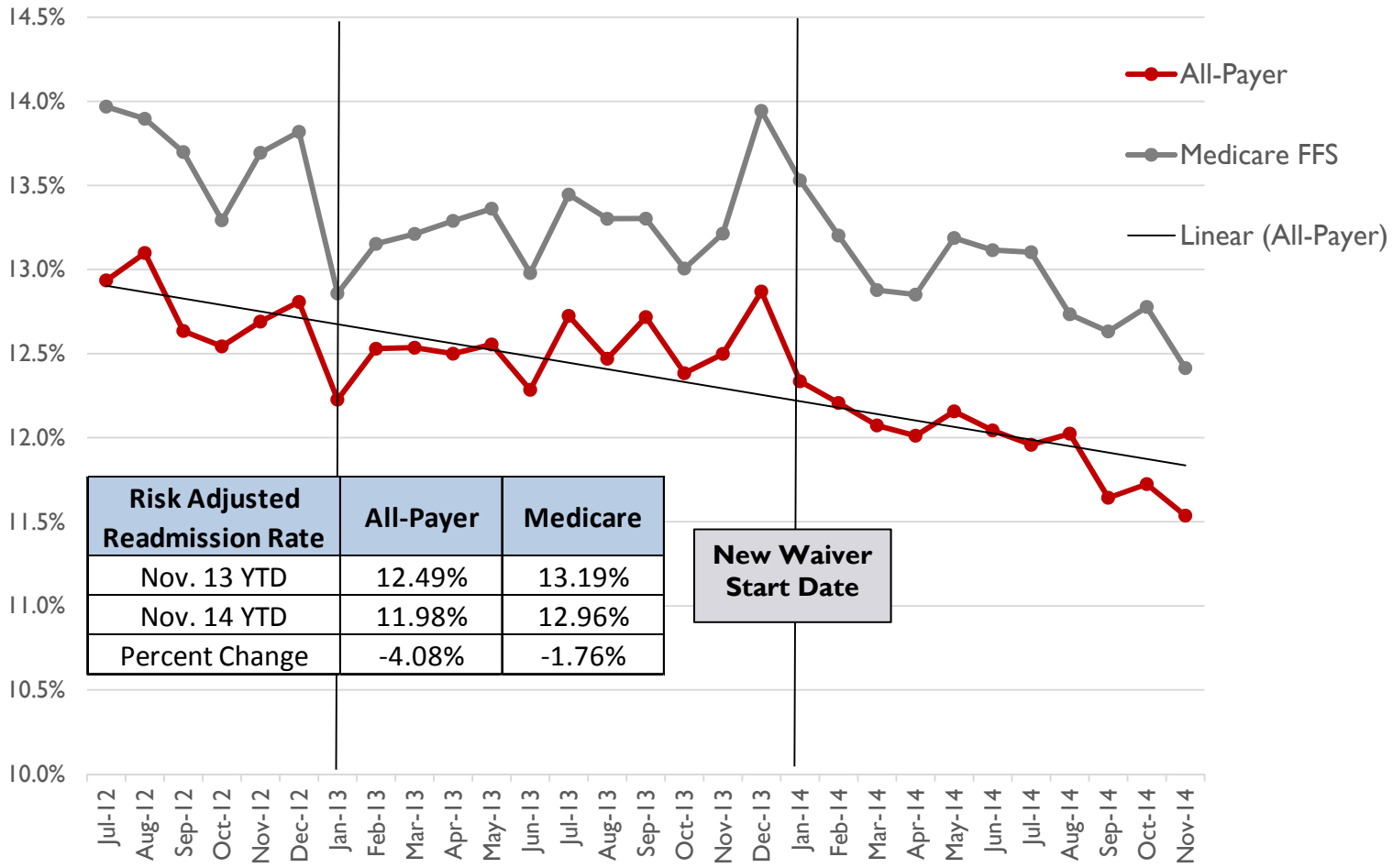
Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2014 and Fiscal 2015 rely on Maryland Department of Planning projections of population growth of .64% (updated December 2014). Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Quality Data

February Commission Meeting Update

Monthly Risk-Adjusted Readmission Rates



Risk Adjusted Readmission Rate	All-Payer	Medicare
Nov. 13 YTD	12.49%	13.19%
Nov. 14 YTD	11.98%	12.96%
Percent Change	-4.08%	-1.76%

Note: Based on final data for January 2013 - September 2014, and preliminary data through December 2014.

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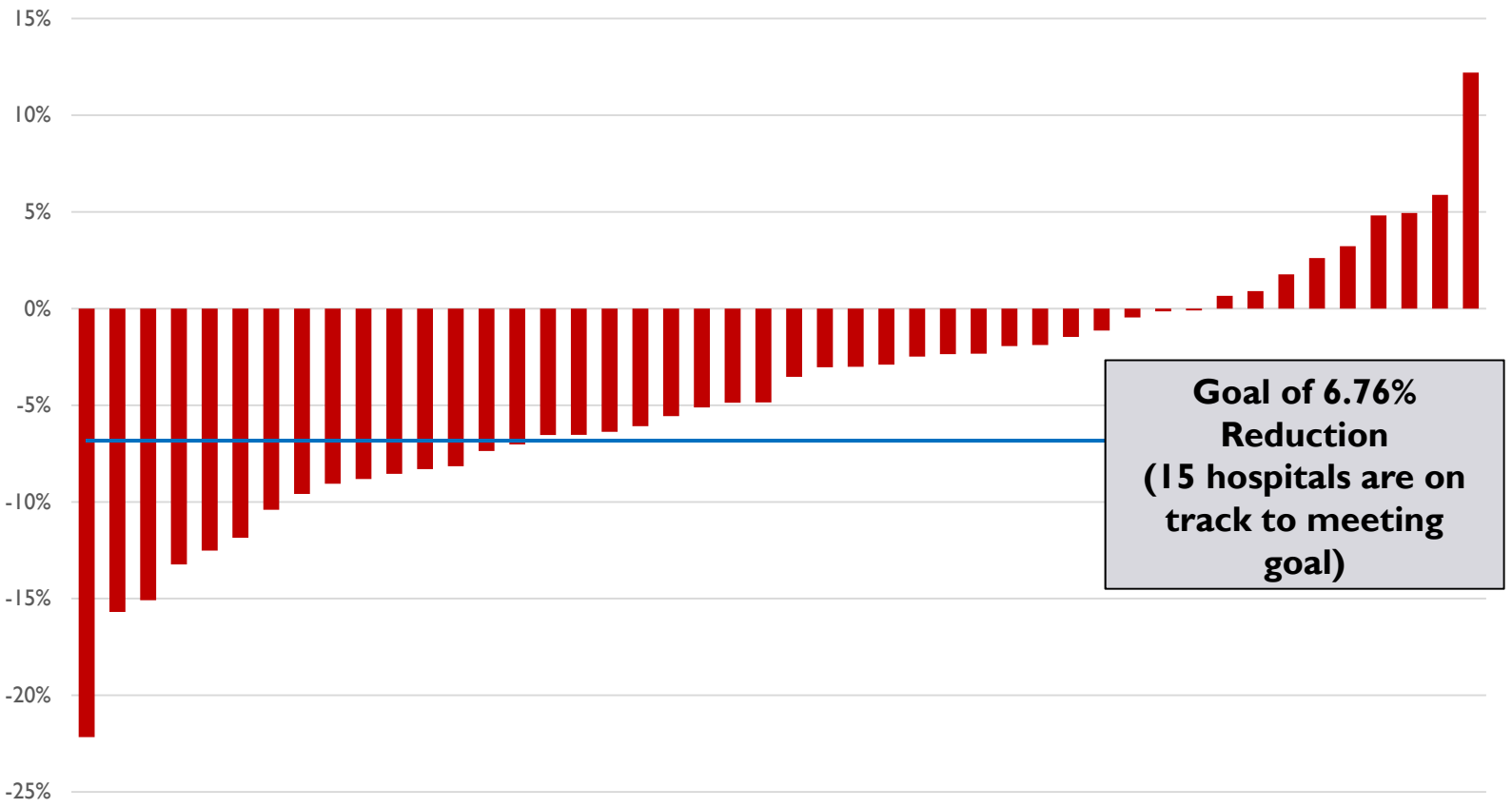
Change in All-Payer Risk-Adjusted Readmission Rates YTD by Hospital



Notes:
Based on final data for January 2013 – September 2014 and preliminary data for July – December 2014.
Percent change is comparing Jan. – Nov. of CY2013 YTD to Jan. – Nov. of CY2014.

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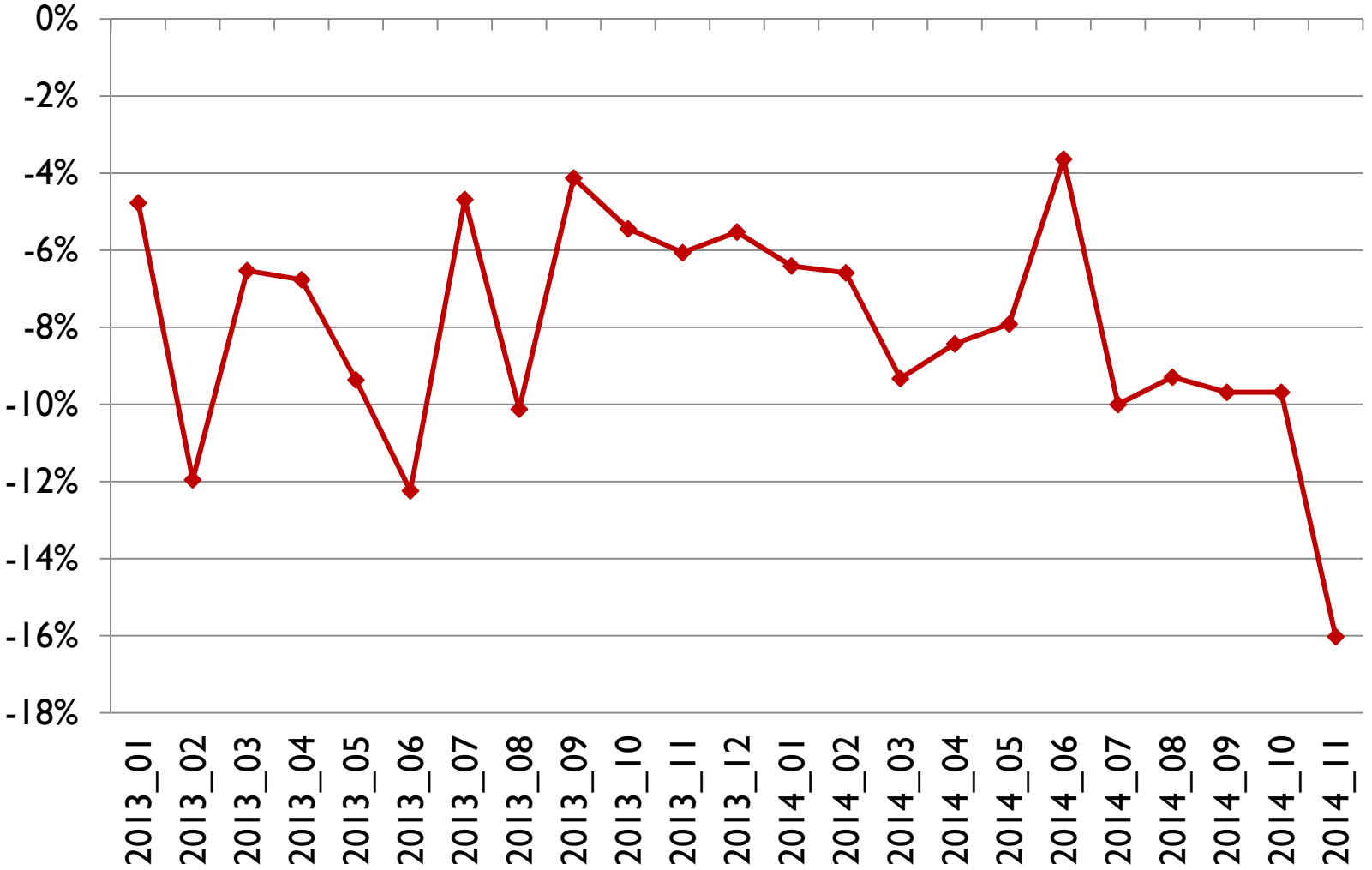
Estimated Percent Change in Number of Readmissions Per Capita From Previous Year



Note: Annual Population Estimates from MD Dept. of Planning

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF FEBRUARY 4, 2015

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
2284R	Garrett County Memorial Hospital	12/23/2014	2/21/2015	5/22/2015	IRC	CK	OPEN
2285R	Johns Hopkins Bayview Medical Center	12/23/2014	2/21/2015	5/22/2015	RAT	CK	OPEN
2287A	University of Maryland Medical Center	1/14/2015	N/A	N/A	N/A	DNP	OPEN
2288R	MedStar Southern Maryland Hospital Center	1/29/2015	2/28/2015	6/29/2015	DEF/MSG	CK	OPEN
2289R	MedStar Franklin Square Hospital Center	1/29/2015	2/28/2015	6/29/2015	DEF/MSG	CK	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*****	**COST REVIEW COMMISSION**
JOHNS HOPKINS BAYVEW	*****	**DOCKET: 2014**
MEDICAL CENTER	*****	**FOLIO: 2095**
BALTIMORE, MARYLAND	*****	**PROCEEDING: 2285R**

Staff Recommendation

(Revised)

February 11, 2015

Introduction

On December 23, 2014, Johns Hopkins Bayview Medical Center (the "Hospital"), a member of the Johns Hopkins Health System, submitted a partial rate application to the Commission for a rate for Radiation Therapy (RAT) services to be provided to both inpatients and outpatients. This new rate would replace its currently approved rebundled RAT rate. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services to inpatients through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for services provided off site, as required by Medicare. In this case, however, as of February 23, 2015, the Hospital will be providing RAT services on-site to both inpatients and outpatients. The Hospital requests that the RAT rate be set at the lower of a rate based on its projected costs to provide RAT services or the statewide median and be effective February 23, 2015.

Staff Evaluation

To determine if the Hospital's RAT rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for RAT services for FY 2015. Based on information received, it was determined that the RAT rate based on the Hospital's projected data would be $29.47 per RVU, while the statewide median rate for RAT services is $28.06 per RVU.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That a RAT rate of $28.06 per RVU be approved February 23, 2015;
2. That no change be made to the Hospital's Global Budget Revenue for RAT services;
3. That the RAT rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2014**
SYSTEM	*	**FOLIO:**	**2096**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2286A**

REVISED

Staff Recommendation

February 11, 2015

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on December 23, 2014, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add heart failure services to its approved global rate arrangement for solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning February 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION ANDASSESSMENT OF RISK

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

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found it to be slightly unfavorable. However, after review of the revised arrangement, staff believes that the Hospitals will be able to achieve a favorable outcome moving forward.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure services for a one year period commencing February 1, 2015. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2015**
MEDICAL CENTER	*	**FOLI O: 2097**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2287A**

Staff Recommendation

February 11, 2015

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on January 12, 2015 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to participate in a global rate arrangement for heart transplant and Ventricular Assist Device services for a period of one year with Cigna Health Corporation beginning March 1, 2015.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff believes that the Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for heart transplants and Ventricular Assist Device services, for a one year period commencing March 1, 2015. The Hospital will need to file a renewal application to be considered for continued participation.

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

VHQC Care Transitions Project and Maryland Readmissions Data

HSCRC Commission Meeting - February 11, 2015

Objectives

- VHQC Overview
- Highlight VHQC's Care Transitions Project
- Present state-specific Medicare claims data

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to better healthcare

VHQC

a. A nonprofit, health quality consulting company
b. Served as Virginia's QIO since 1984
c. CMS National Coordinating Center contracts
d. Health IT Regional Extension Center

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New Approach for QIOs

2014 - 2019

Beneficiary and Family Centered Care

(BFCC) QIOs

5 Regions

Quality Innovation Network

(QIN) QIOs

14 Regions

Appeals, Complaints, Higher-Weighted DRGs, EMTALA

QI Projects

KEPRO

844-455-8708

www.keproqio.org

VHQC

804-289-5320

www.vhqc.org

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QIN Aims

Better Health	Better Care	Lower Costs
• Improving cardiac health & reducing cardiac disparities • Reducing disparities in diabetes care • Coordinating care through Immunization IS • Coordinating prevention through HIT	• Reducing care-associated infections (Hospital HAIs) • Reducing care-acquired conditions (SNFs) • **Coordinating care to reduce readmits & adverse drug events**	• Quality Improvement through Physician Value Modifier • Local QIO Projects

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Connecting Care Project Goals

- Engaging communities of clinical and local service/support partners
- Improve care for Medicare beneficiaries
  - Reduce 30-day re-hospitalizations by 20%
  - Reduce overall hospitalizations by 20%
  - Increase # of nights beneficiaries spend at “home” by 10%
  - Reduce adverse drug events (ADEs) by 35%
  - Effective community interventions >60%
- Build community capacity to qualify for formal program or grant funding
- Spread successful care transitions interventions

Additional Areas of Focus

- ADEs
- Dual-eligible/enrolled beneficiaries
- Rural issues

- Community Special Populations of Focus
  - Multiple chronic conditions
  - Behavioral health
  - Alzheimer's and other related dementias
  - Disparities

Community Organizing

- Assess current efforts
- Define appropriate geographic area
- Identify key partners
- Support coalition development
  - Charter
  - Organizational structure
- Plan community meetings
  - Informational sessions
  - Recruitment within local area partners
  - Kick-off
  - Action

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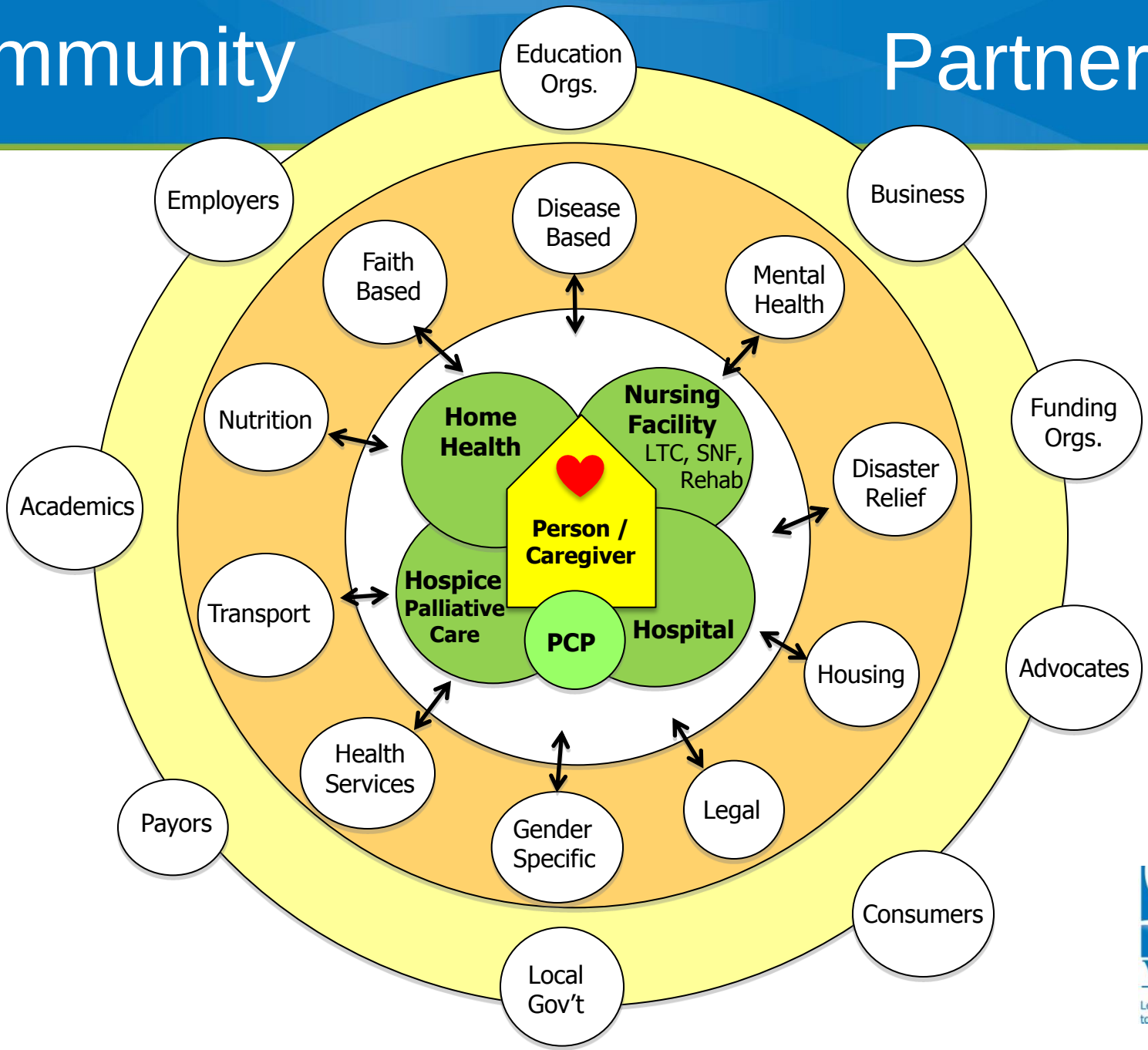
Community Partners



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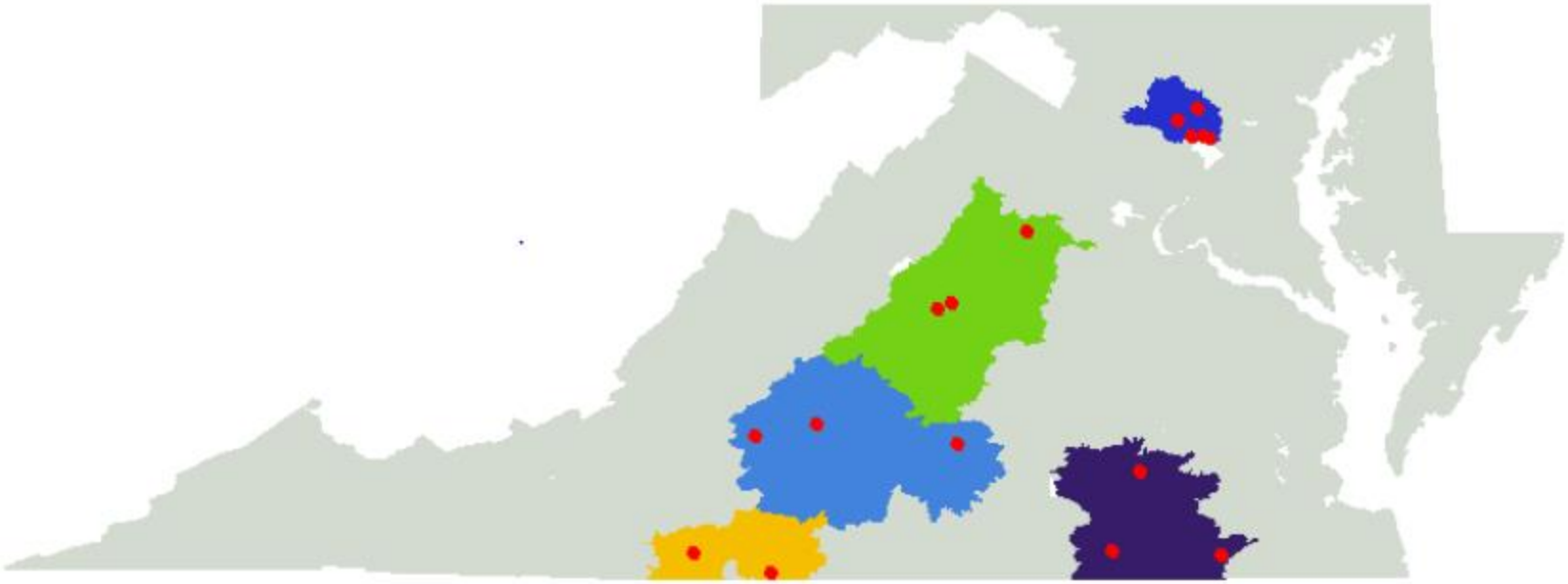
Existing Community Efforts VA/MD



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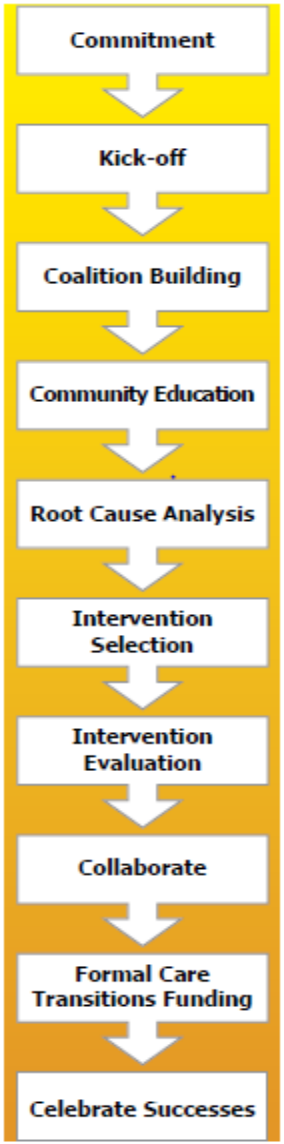
Activities & Technical Assistance



- Community Organizing
  - Coalition building, meeting and workgroups
- Root Cause Analysis
- Community Action Plans
- Measurement and Evaluation
- Promoting Learning and Action
- Sharing Successes
- Formal Funding

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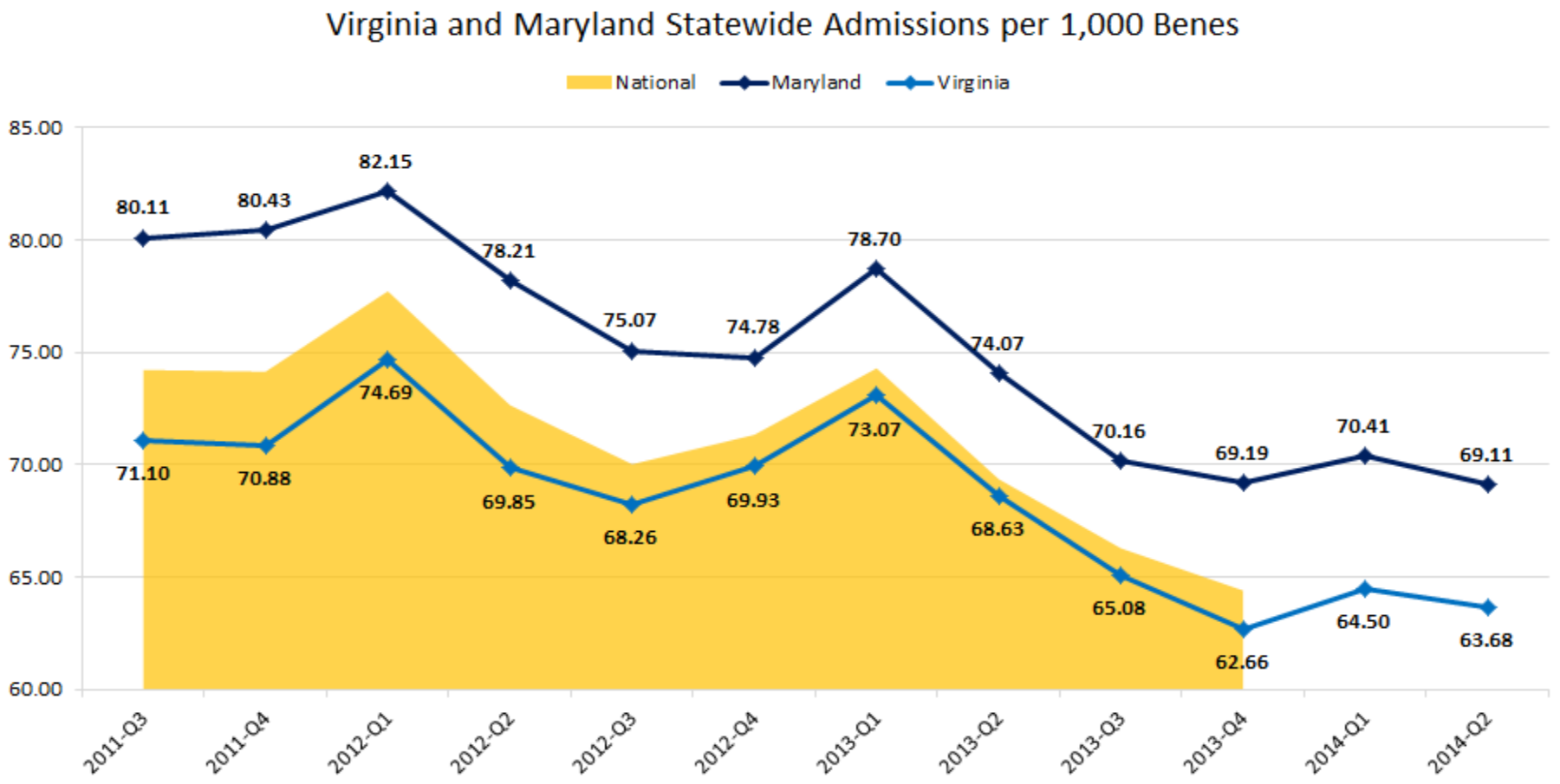
Admissions per 1,000 FFS Beneficiaries



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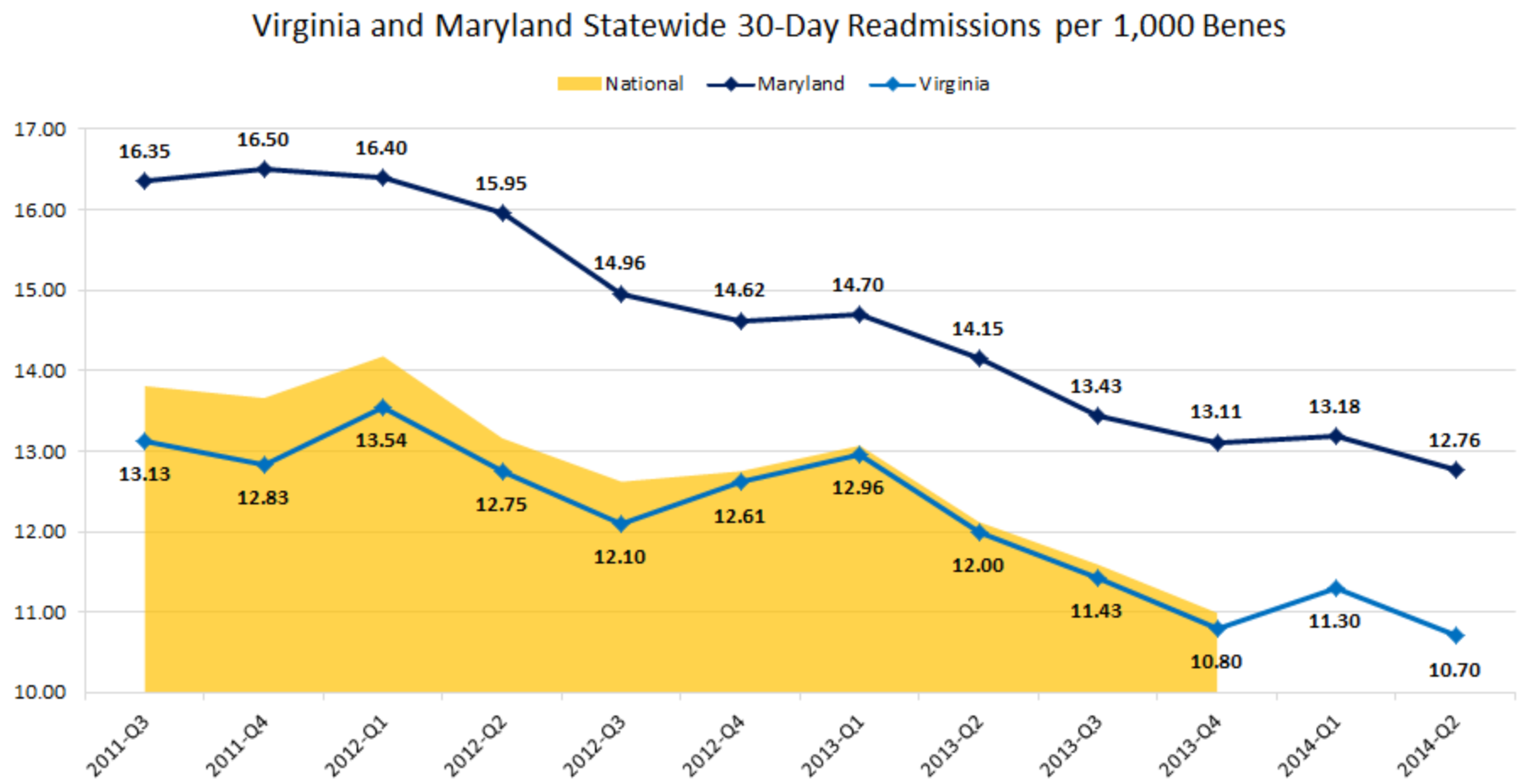
Readmissions per 1,000 FFS Beneficiaries



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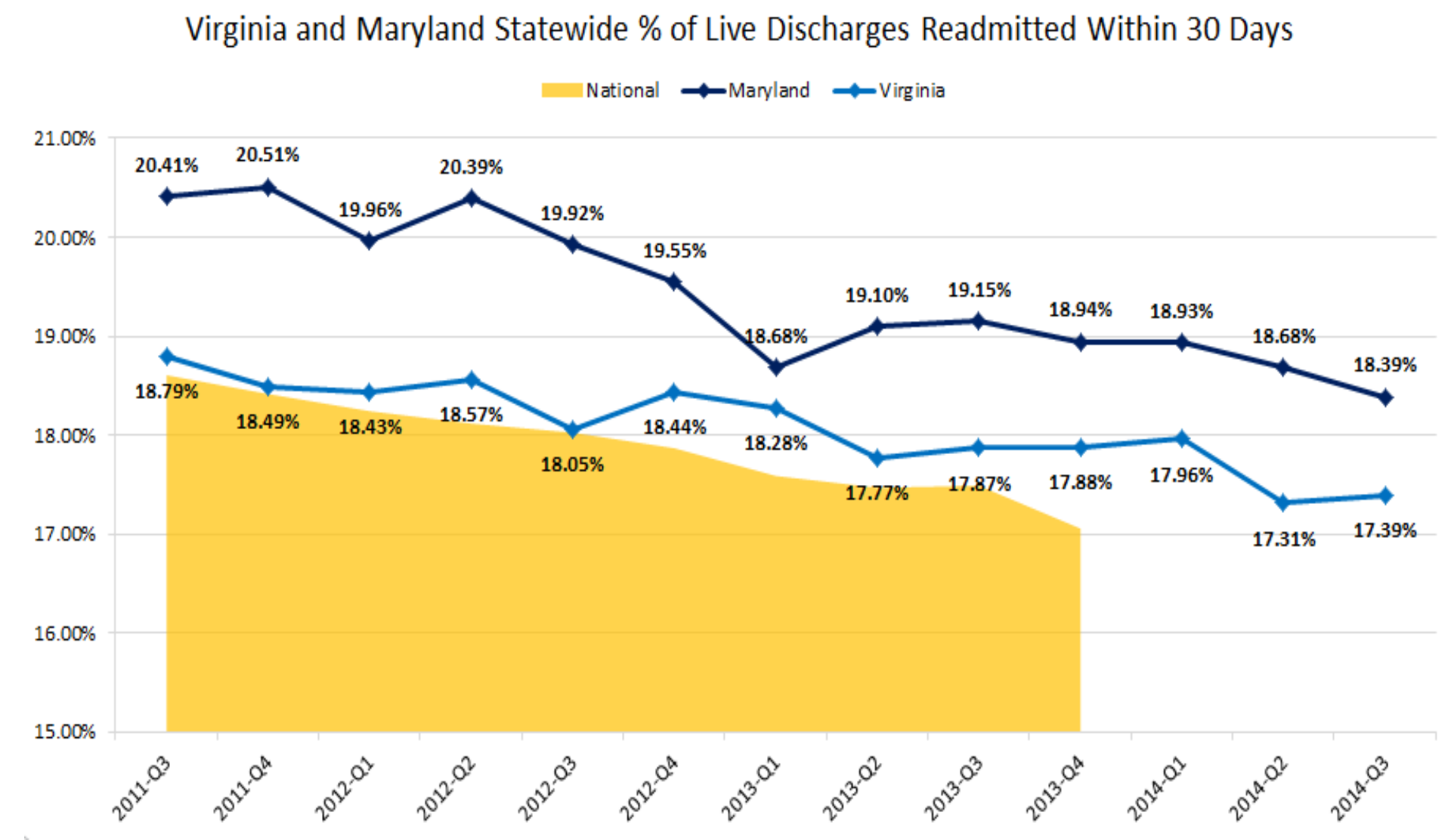
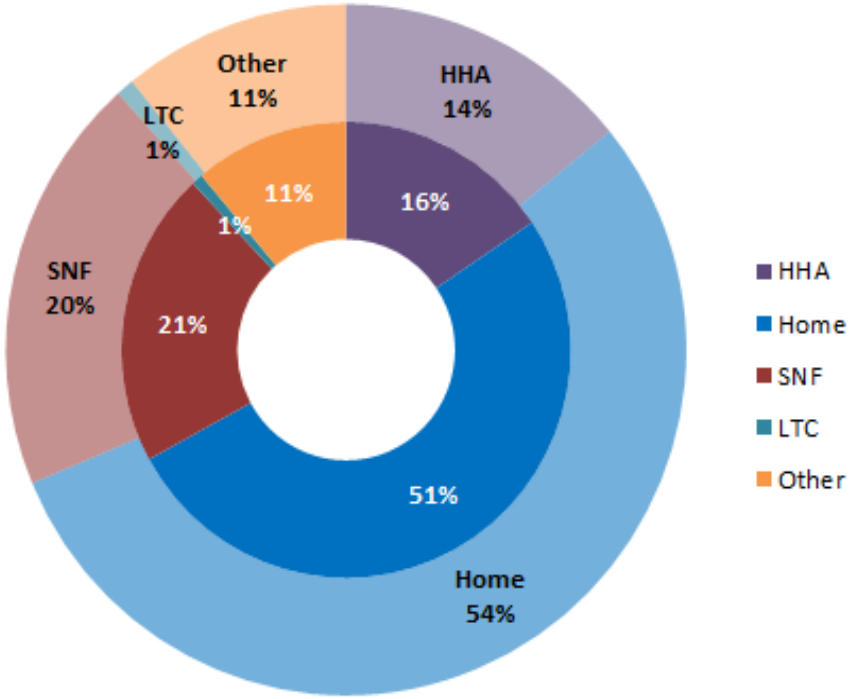
30-Day Readmissions/Discharges Rates



Readmissions by Discharge Destination

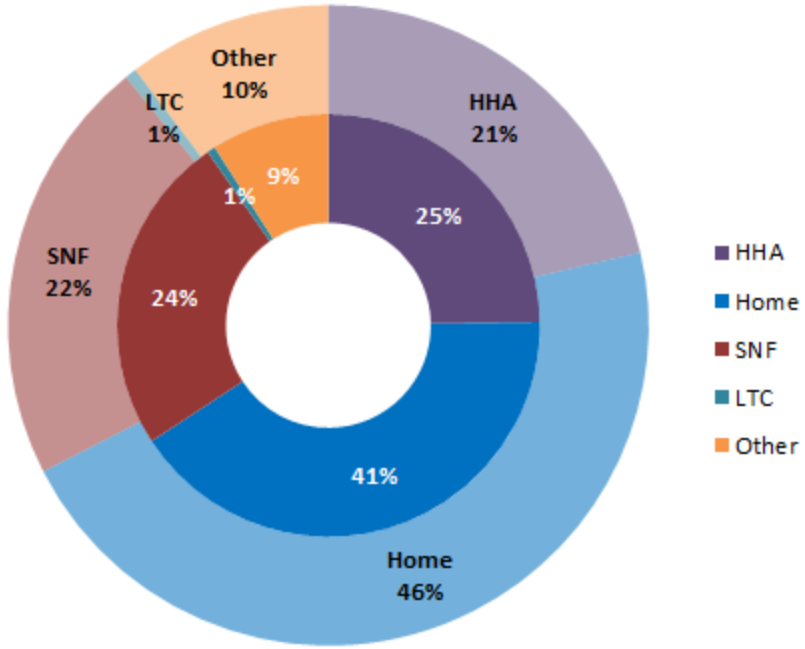
Jan.2014 – July 2014

Maryland Discharge Destination Admissions and Readmissions Distribution



Note- Admissions outside; readmissions inside

Virginia Discharge Destination Admissions and Readmissions Distribution



Note- Admissions outside; readmissions inside

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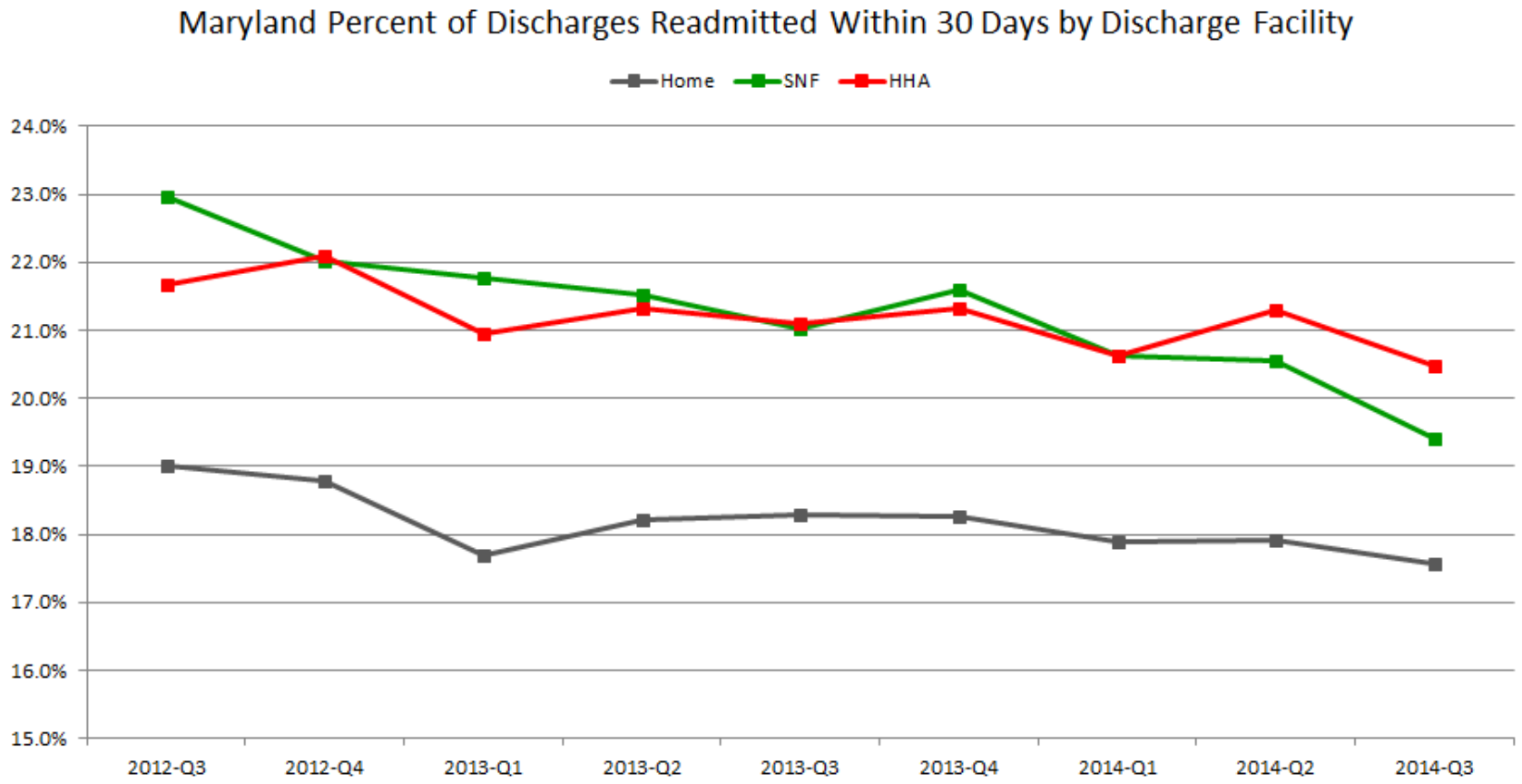
Readmissions by Discharge Location over Time



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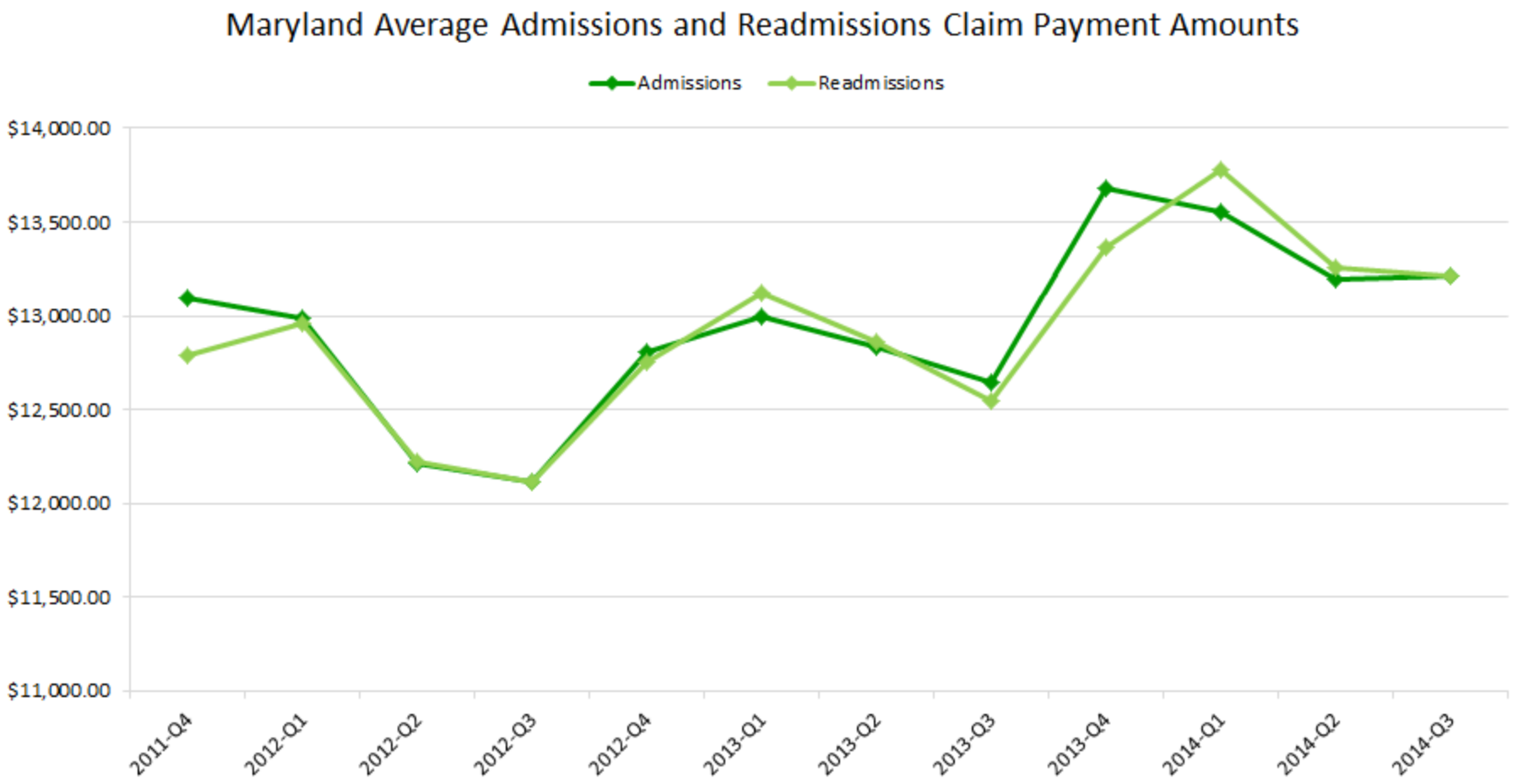
Average Medicare FFS Claim Amounts



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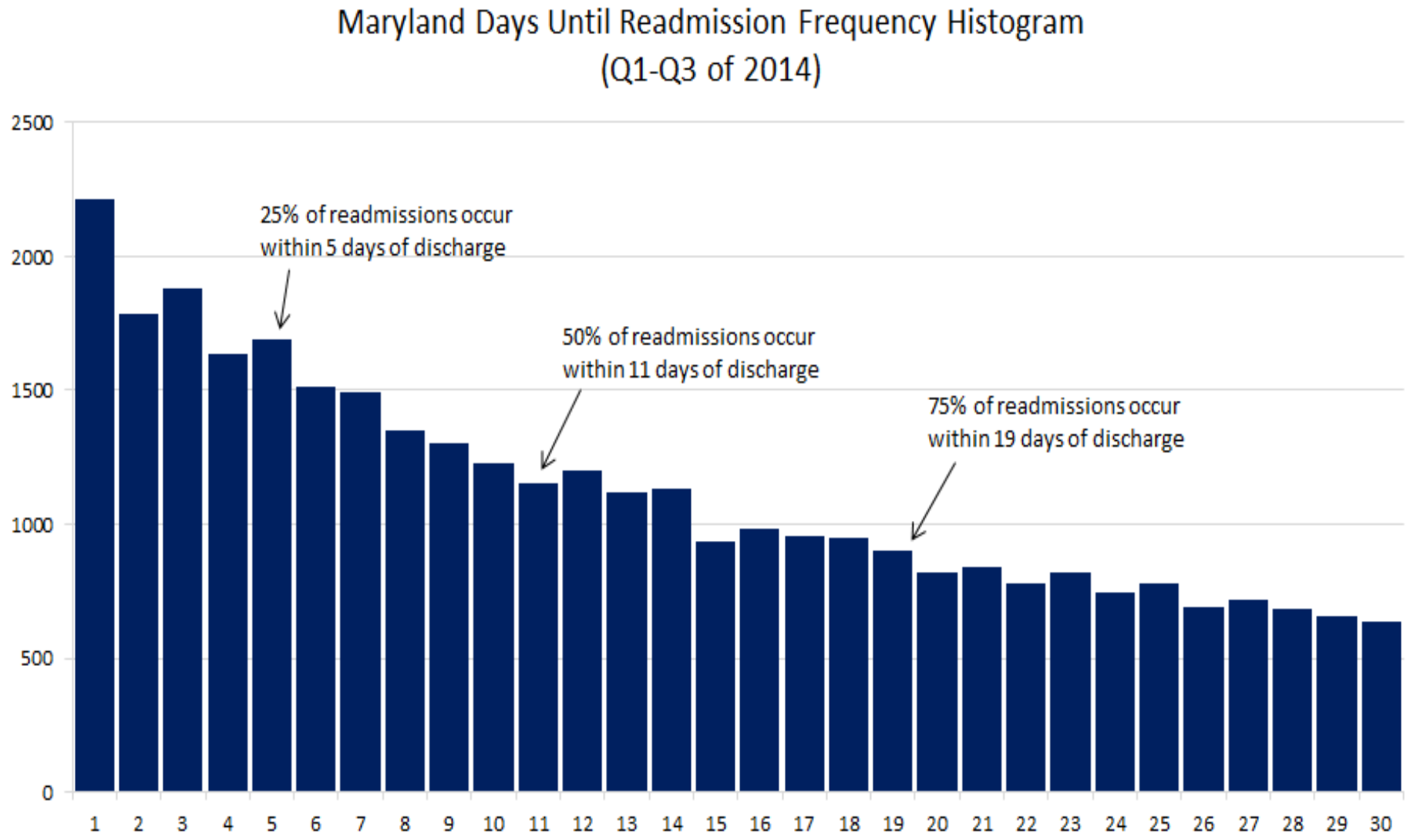
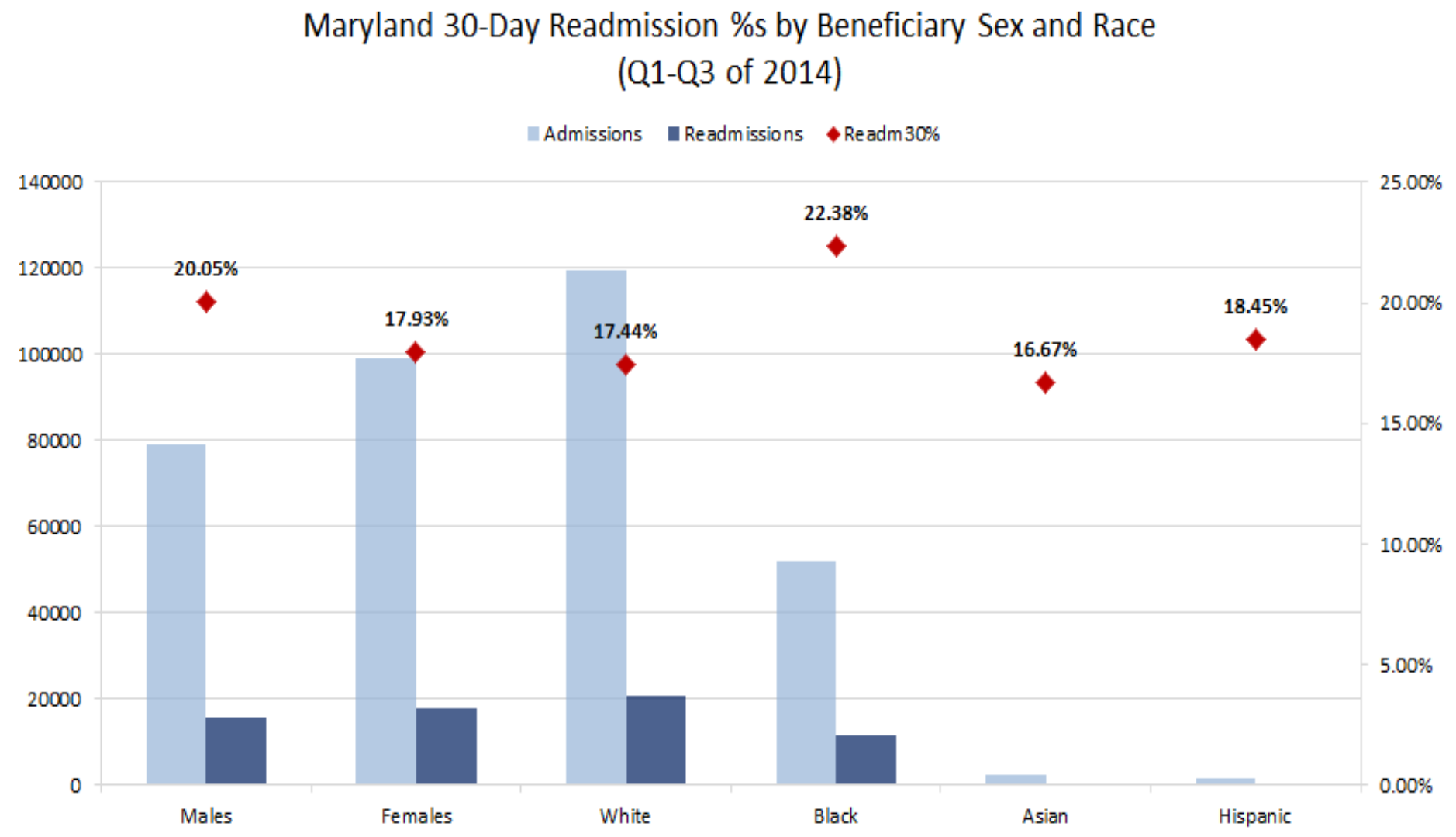
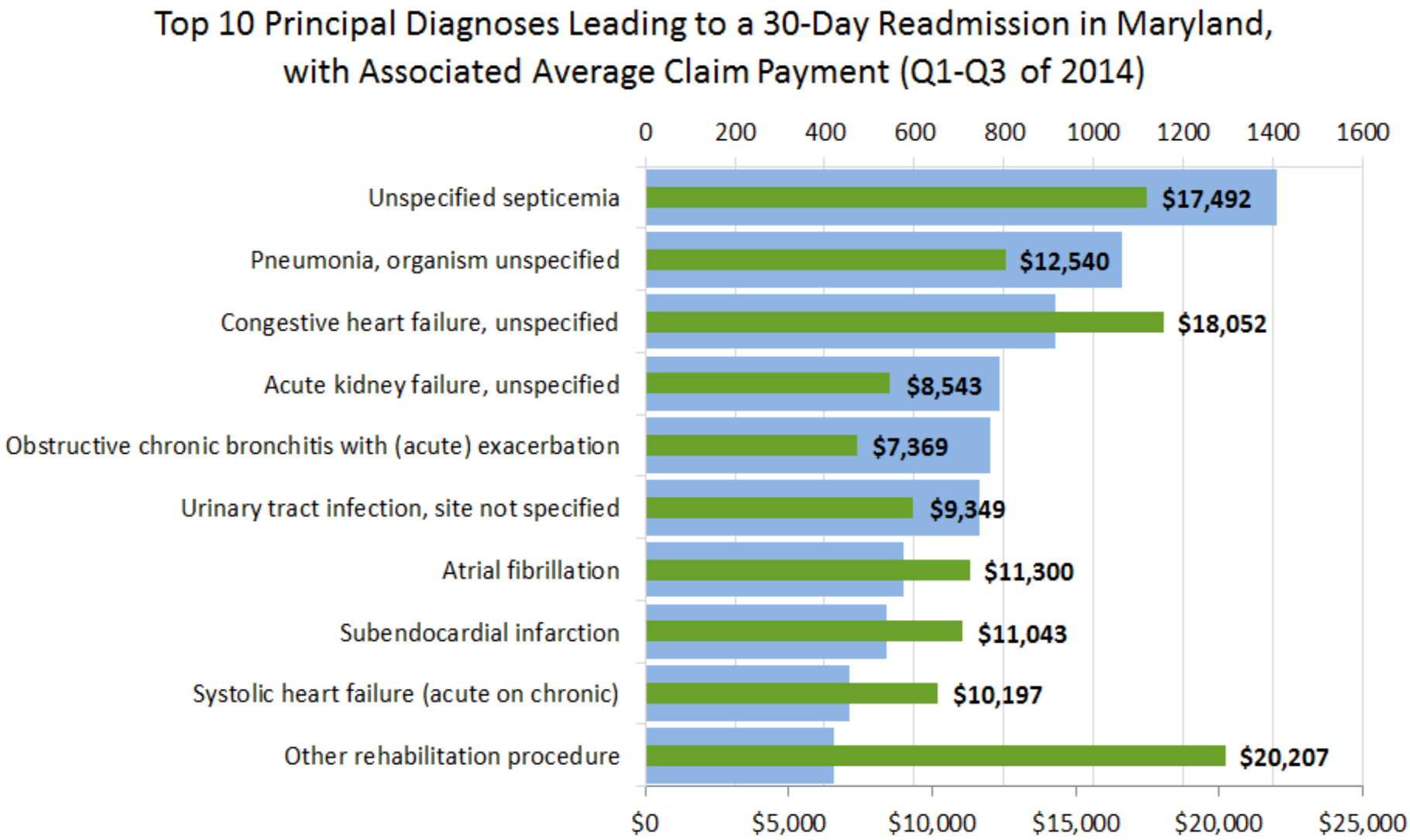
Days until Readmission



Readmissions by Sex & Race



Top Index Diagnoses Leading to Readmissions



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This material was prepared by VHQC, the Medicare Quality Improvement Organization for Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. VHQC/C.3.CT/2/8/2015/2091

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State of Maryland
Department of Health and Mental Hygiene

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David Romans
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

To: HSCRC Commissioners

From: Sule Calikoglu, PhD. Deputy Director

Re: Update on the Recommendations for the Readmission Reduction Incentive Program for FY2017

Date: February 4, 2015

Since presenting the draft recommendations for the Readmission Reduction Incentive Program for FY2017 at the December commission meeting, staff has been discussing the recommendations with the payment and performance work group members, and working with Center for Medicare and Medicaid Innovation (CMMI) to update the readmission rates. Staff is planning to present the final recommendations at the March commission meeting and is providing the following updates.

- **Statewide Readmission Reduction Target:** CMMI is currently revising the measure specifications for the readmission measure. Staff has not yet received the final readmission rates for Maryland and Nation, as well as trend analysis to model the required readmission reduction rate for CY2015. We are expecting to receive the new data by the end of February.

- **Performance Measurement:** There is a concern about the correlation between the all-payer readmission rate and the Medicare FFS readmission rate. CY2014 performance year to date shows lower reductions in Medicare FFS readmission rate compared to the all-payer readmission rate. While basing the payment adjustments on an all-payer measurement is in line with the general principles of quality programs, using Medicare readmission rates may assure the performance is directly tied with contractual agreement with CMMI.

- **Scaling Approach:** As presented in the draft recommendation, staff is working on adjusting the payment incentives to establish negative adjustments as well as the positive adjustments. In addition there have been discussions on whether the payment scale should be tied to the state-wide performance in readmission reductions.

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To: HSCRC Commissioners

From: Sule Calikoglu, PhD. Deputy Director

Re: Update on the Recommendations for Aggregate Revenue Amount at-Risk Under Maryland Hospital Quality Programs for FY2017

Date: February 4, 2015

Since presenting the draft recommendations for Aggregate Revenue Amount At-Risk Under Maryland Hospital Quality Programs for FY2017 at the December commission meeting, staff has been discussing the recommendations with the payment and performance work group members. Staff is planning to present the final recommendations at the March commission meeting and is providing the following updates.

- **Approach to determine maximum revenue adjustments:** The All-Payer Model Agreement with CMMI requires that the proportion of Maryland hospitals' revenues held at risk for quality programs be equal to or greater than the proportion of revenue that is held at risk under national Medicare programs. The objective of this requirement is two-fold: a) incentivize hospitals to deliver high quality care in support of the Triple Aim of better care, better health, and lower cost, and b) evaluate the extent to which Maryland quality programs are rewarding value as compared to those of the national Medicare program. The aggregate potential at risk in Medicare programs for FY2017 is 6% of hospital inpatient revenue. Staff is determining the maximum at risk amounts according to the specifics of each program and ensuring that we fulfill the requirements of the contract. Recognizing the large improvements in the MHAC program, staff is proposing to reduce the maximum amount at risk for this program while increasing the amounts for QBR and readmissions to incentivize much needed improvements in patient experience and readmission rates.

- **Hospital Aggregate Amount at Risk Limit:** As we increase the maximum revenue adjustments statewide, concerns have been raised about the potential for a particular hospital to receive large revenue reductions resulting in unmanageable financial risk. Staff is evaluating a potential to limit total reductions at hospital level

- **Revenue-neutrality requirement:** All stakeholders agree that, under the new all-payer per capita limit, the rewards for better quality do not need to be limited to penalties collected from each program. Work groups will be discussing how revenue neutrality can be structured on an overall basis in relation to the update factor.

- **Changing QBR scaling from relative ranking to point based scale**: To align all hospital quality-based programs, staff is proposing to remove revenue neutrality requirement from QBR scaling and change the scaling methodology from relative ranking to a point-based adjustments for FY2017.

- **Removing revenue neutrality requirement for MHAC program FY2016**: As a result of large improvements in the PPC rates, staff is proposing to remove revenue neutrality requirement from MHAC program retrospectively for FY2016.

Below tables provide the draft recommendations for maximum at risk and summary modeling results.

Table 1: Draft Proposed Maximum Penalties and Rewards for FY2017

	FY 2016		FY2017 Draft Proposed	
	Max Penalty	**Max Reward**	**Max Penalty**	**Max Reward**
MHAC Below target	-4%	0%	-3.0%	0.0%
MHAC Above Target	-1%	1%	-1.0%	1.0%
RRIP	0%	0.50%	-2.0%	1.0%
QBR	1%	Na	-2.0%	1.0%
Estimated :				
Shared Savings	-1.23%	0%	-1.23%	0.00%
PAU	-0.86%	0%	-0.86%	0.00%
Total	**-5.1%**	**0.5%**	**-9.1%**	**2.0%**

Table 2: Modeling Summary Results based on Draft Proposed Fy2017

	Penalties	Rewards	Net
MHAC Below Target	$ (123,076,937)	$ -	$ (123,076,937)
MHAC Below Target w/ 0.5% Penalty Limit	$ (44,805,157)	0	$ (44,805,157)
MHAC (8% Improvement)	$ (25,254,412)	$ 720,358	$ (24,534,053)
RRIP (Single Scale)	$ (58,460,168)	$ 34,156,790	$ (24,303,378)
RRIP (Target not met)	$ (58,460,168)	$ 17,078,395	$ (41,381,773)
RRIP (Target met)	$ (20,972,600)	$ 34,156,790	$ 13,184,190
QBR (current Scaling)	$ (24,158,764)	$ 32,845,658	$ 8,686,893
QBR (preset Scaling)	$ (24,158,764)	$ 21,919,343	$ (2,239,421)
Net Impact			
MHAC (Below Target)	$ (157,420,431)	$ 7,800,694	$ (149,619,736)
Percent Inpatient Revenue	-1.8%	0.1%	-1.7%
Percent Total Revenue	-1.1%	0.1%	-1.0%
Maximum Net Hospital Impact as Percent Inpatient	**-5.4%**	**2.0%**	
MHAC (8% Improvement)	$ (77,569,383)	$ 26,492,531	$ (51,076,852)
Percent Inpatient Revenue	-0.9%	0.3%	-0.6%
Percent Total Revenue	-0.5%	0.2%	-0.3%
Maximum Net Hospital Impact as Percent Inpatient	**-3.5%**	**2.4%**	

Update on Work Groups

- GBR Market Shift Draft Principles
- Uncompensated Care
- Care Coordination

HSCRC
Health Services Cost Review Commission

Market Share Adjustments (MSAs) Draft Principles--Purpose

- Purpose of MSAs is to provide a basis for increasing or decreasing the approved regulated revenue of hospitals operating under global revenue arrangements to ensure that revenue is appropriately reallocated when shifts in patient volumes occur between hospitals.
  - Support objectives of Triple Aim
  - Fundamentally different than a volume adjustment
  - Independent of general volume increases
  - Focus is on "shifts" rather than share

Market Share Adjustments (MSAs) Draft Principles--Application

- Applied as part of global budget mechanism.
- Only one of many mechanisms.
- Examples of other situations where global budgets might be adjusted for changes in volumes include;
  - Opening of a new hospital,
  - Increases in transfers of patients,
  - Discontinuation of services, changes in levels of services,
  - Shifts to unregulated settings, or
  - Actions that undermine the Triple Aim.

Market Share Adjustments (MSAs) Draft Principles--Features

- Specified population
  - Staff is using a virtual service area based on zip codes for urban and suburban hospitals. More defined service area used for rural areas, or aggregation of "geo zips".
- Defined set of covered services
- Budget neutral to maximum extent practicable
- Generally excludes reductions in potentially avoidable utilization

Calculations—Shift, not share

- The Math
  - If a hospital's volume increases in a particular service and zip code (or market area for rural areas) and no hospitals have volume decreases, there is no adjustment
  - If one hospital's volume decreases and another increases, the limit of the shift adjustment is based on the lesser of the two

Market Share Adjustment Work in Progress

- A work in progress
- Turning to define the calculation of the revenue transfer
  - Intend to utilize 50% variable cost in routine calculations
- Topics to be reviewed include
  - Approach to calculating budget adjustments
  - Possible use of corridors for minor variations
  - Timing
  - Relative value

Uncompensated Care
CRISP Analysis Used to Understand Impact of ACA

- Inconsistent Reporting of Medicaid Pending in HSCRC Case Mix Data limits value of analyzing trends.
  - Issue resolved using CRISP to match HSCRC data with Medicaid enrollment files
- Some charges reported in case mix as Medicaid were not associated with a Medicaid enrollee during a Medicaid coverage period.
  - These charges were re-categorized as self-pay charity
- Some charges reported in case mix as self-pay/charity were associated with Medicaid enrollee during a Medicaid coverage period
  - These charges were re-categorized as Medicaid

	2013	2014	Change
Self-Pay/Charity Charges in Case Mix Data	**357**	**183**	
Remove Charges Associated with Medicaid Coverage Period	-75	-27	
Add Charges recorded as Medicaid but not Associated w/ Medicaid Coverage Period	165	140	
	446	**296**	**-150**

Data Supports Removing $100 M+ from FY 2016 Rates

Annualized Self-Pay/Charity Decline ($150 M x 2)	$299 M
UCC Policy Adjustment for PAC In FY 2015 Rates	-$166 M
UCC/Charity Decline Exceeds PAC Adjustment	$133 M

- Six month data annualized rather than updating for full CY 2014 experience as Medicaid enrollment files for more recent periods are less reliable due to retroactive eligibility determinations.

Care Coordination WG January 23

- Acquiring and using Medicare data and other actionable information for care coordination
- Begin discussion on essential care coordination and chronic health improvement activities to categorize as:
  - Statewide;
  - Regional; or
  - Provider-based
- Draft recommendations were developed and sent to Work Group following meeting

Medicare Data Draft Recommendations

- The Draft Recommendation takes a two-track approach:
  - Use existing available data sets (including HIE and HSCRC data) to conduct risk stratification and identifying high-risk patients particularly related to ED use, admission, readmissions, and chronic diseases. Consider other sources such as:
    - Pharmacy benefit managers data;
    - Outcome and Assessment Information Set (OASIS) on home care
    - Minimum Data Set (MDS) on nursing home care
    - Medications lists, lab values, and immunization records
  - Obtain access by providers, in a secure and protected way, to confidential Medicare data for care coordination consistent with the All-payer model for defining patient-provider relationships, risk stratification, care management, and care planning.

February 12 Care Coordination WG Agenda 2-5 PM at HSCRC

- Continued conversation on promising care coordination practices and whether investments are most appropriate at the state or regional level.
- Explore the core components of individualized, patient centered care planning
- Consider important facets of comprehensive care planning from both the clinical and social perspective.

DRAFT DOCUMENT FOR COMMISSION DISCUSSION

Principles for Market Share Adjustments under Global Revenue Models

This draft document, prepared in conjunction with the Payment Models Work Group, contains principles for consideration as market share adjustments are developed and applied. It is a work in progress and may be modified as the approaches and calculations for adjustments are finalized.

Introduction

The Market Share Adjustments (MSAs) mechanism is part of a much broader set of tools that link global budgets to populations and patients under the State's new All-Payer Model.

The specific purpose of MSAs is to provide a basis for increasing or decreasing the approved regulated revenue of Maryland hospitals operating under Global Budget Revenue (GBR) rate arrangements to ensure that revenue is appropriately reallocated when shifts in patient volumes occur between hospitals as a result of efforts to achieve the Triple Aim of better care, better health, and lower costs. MSAs under a global budget revenue system are fundamentally different from a volume adjustment. Hospitals under a population-based payment system have a fixed budget for providing services to the population in their service area. By definition, a global budget is not fixed if it is subject to volume adjustments. Therefore, it is imperative that MSAs reflect shifts in patient volumes independent of general volume increases in the market. Additionally, MSAs should not be so sensitive that they respond to random fluctuations in the volume of services at individual hospitals.

This document lays out the principles governing the development of MSA mechanisms that will be applied as part of Maryland's global budget system—the specific adjustments are being developed and are expected to evolve over time.

Overview

In order for an MSA to be consistent with a population-based approach, it should have certain features such as the following:

- A specified population from which hospitals' market shares will be calculated;
- A defined set of covered services of the MSA ; and
- An MSA approach that is budget neutral to the maximum extent practicable and/or results in demonstrably higher quality.

Principles for Market Share Adjustments under Global Revenue Models

The MSA should not hinder the global budget incentive to eliminate marginal services that do not add value, are unnecessary or result from better community based care. Therefore, MSAs should not be applied for such appropriate reductions in utilization. MSAs are just one mechanism necessary to account for changes in levels and patterns of utilization. The global budget agreements also contain mechanisms intended to ensure the continued provision of needed services for Maryland patients including:

- **Population/Demographic Adjustments:** Changing demographics may result in growth in the demand for services. The annual update factor adjusts revenue to capture changes in overall population. Annual hospital level population adjustments will capture changes in total population/demographics in each patient service area.
- **Annual Update Provides Flexibility to Fund Innovation/New Services/Growth in Selected Quaternary Services:** Targeted funding can be provided through the Update Process. For example, the new Holy Cross Germantown Hospital was partially funded from the general update process. Consideration is given to annual budget changes for quaternary services such as transplants, burns, and highly specialized cancer care for Johns Hopkins Hospital and University Hospital Center under their global budget agreements.
- **Transfers to Johns Hopkins Hospital, University Hospital Center, and Shock Trauma Center:** Adjustments will be made for increases in transfers to these centers to ensure that resources are available to treat patients needing the specialized care provided in these settings.
- **Potentially Avoidable Utilization (PAU**): PAU is excluded from the market share analysis and will be analyzed separately. Exclusion of PAU from the general market share analysis avoids the potential to reward a hospital that increased PAU at the expense of a hospital that appropriately reduced PAU. A PAU focused analysis, when warranted, will allow an assessment PAU reductions that are not driven by improvements in population health, such as diversion of patients to an unregulated setting, transfer of patients due to changes in referral patterns by purchasers, or a less favorable change in service delivery (eliminating or contracting service lines that have high PAU volumes) that should not be rewarded.

The basis for distinguishing between desirable and undesirable utilization changes is the Triple Aim of the new system: to improve health care outcomes, enhance patient experiences, and control costs. MSAs, together with other global budget agreement provisions and HSCRC policies, will need to focus on efforts that support the Triple Aim.

Examples of actions that help achieve the Triple Aim are those that result from:

- Providing high quality hospital care resulting in fewer hospital-acquired conditions;
- Making efforts to improve care coordination and patient discharge planning resulting in fewer re-hospitalizations;

- Promoting the provision of care in the most appropriate setting, resulting in fewer initial hospitalizations for ambulatory care sensitive conditions and conditions that can be treated equally effectively in other settings at lower cost; and
- Providing services in a lower cost settings without compromising patient care.

Possible examples of actions that undermine the Triple Aim and should be avoided include:

- Prompting patients with unprofitable service needs to seek care elsewhere or reducing the volume of non-profitable services below the amount needed by patients within the hospital's service area;
- Reducing capacity or service ability to the point of creating long waiting lists or delays;
- Under investing in new technology or modes of care proven to be efficient ways of improving patient health, safety or quality; and
- Reducing the total level of a hospital's medical staff or the quality of affiliated providers to the point of compromising patient care.

Similarly, the MSA together with other mechanisms and policies must distinguish between increases in utilization at any given hospital that should be recognized and those that should not be recognized. For example, hospitals should receive increases to their approved regulated revenue in circumstances that result in a shift of patient volumes that are beyond the hospital's control, such as the closure of a service at a particular hospital and resulting relocation of patients receiving that service to another facility, or other discrete and readily identifiable events. As long as the financial drivers of the shift are transparent and value based, hospitals should also receive a market share adjustment if organizations such as Health Maintenance Organizations, Accountable Care Organizations or Primary Care Medical Homes direct their members to the facility to improve efficiency, cost-effectiveness and quality.

The MSA policy should not encourage shifts in volume that are not clearly relatable to improvements in the overall value of care, such as marketing or acquisition strategies that merely shift the location or ownership of resources without increasing access, improving outcomes, or reducing costs in a geographic area. In February 2014, the Commission reduced the variable cost factor for volume changes from 85% to 50% for services provided outside of global budgets that are subject to the All Payer Model. Applying this lower variable cost factor to market share adjustments will contribute to limiting incentives to increase volume through strategies that do not improve care or value.

Guiding Principles

In developing its MSA approach, the HSCRC should follow certain guiding principles. These include:

DRAFT DOCUMENT FOR COMMISSION DISCUSSION

Principles for Market Share Adjustments under Global Revenue Models

1. **Provide clear incentives**
   - **1.1.** Promote the three part aim
   - 1.2. Emphasize value, recognizing that this concept will take some time to develop
   - 1.3. Promote investments in care coordination
   - 1.4. Encourage appropriate utilization and delivery of high quality care
   - 1.5. Avoid paying twice for the same service

2. **Reinforce the maintenance of services to the community.**
   - 2.1. Encourage competition to promote responsive provision of services
   - 2.2. Competition should be based on value
   - 2.3. Revenue should generally follow the patient
   - 2.4. Support strategies pursued by entities such as ACOs, PCMH, and MCOs seeking to direct patients to low cost, high quality settings

3. **Changes constituting market share shifts should be clearly defined.**
   - 3.1. Volume increase alone is not a market share change.
   - 3.2. Market share shifts should be evaluated in combination with the overall volume trend to ensure that shift has occurred, rather than volume growth
   - 3.3. If one hospital has higher volume and other hospitals serving the same area do not have corresponding declines in volume, a market share shift should not be awarded.
   - 3.4. Increases in the global budget of one hospital should be funded fully by the decrease in other hospitals' budgets
   - 3.5. Market share changes should reflect services provided by the hospital
   - 3.6. Substantial reductions at a facility may result in a global budget reduction even if not accompanied by shift to other facilities in service area. (Investigate shift to unregulated, limitations on types of procedures)
   - 3.7. Closures of services or discrete readily identifiable events should result in a global budget adjustment and a market share adjustment as needed
   - 3.8. Market shifts in Potentially Avoidable Utilization (PAU) should be evaluated separately[1]

[1] There are limited circumstances where HSCRC might want to recognize a market shift in PAUs. For example, if an HMO moved all of its patients from one facility to another, there may be an appropriate shift in revenue for some level of PAU cases. Similarly, if a PCMH changed its hospital affiliation, there may be a shift in PAU volumes from one facility to another.

DRAFT DOCUMENT FOR COMMISSION DISCUSSION

Principles for Market Share Adjustments under Global Revenue Models

Topics to Be Reviewed after Methodology Development for Calculating Shift

1. Adjust budgets for substantial shift in market share
2. Use corridors to avoid shifts for minor variations
3. Adjust budgets gradually to reflect the fixed nature of capital and other costs
4. Timing of market share adjustments
5. Relative value of market shifts

Market Share Shift Calculation

Based on the principles listed above:

- **Both** volume and market share at a hospital must have increased to receive a positive market share adjustment.
- **Both** volume and market share at a hospital must have decreased to receive a negative market share adjustment.

The developed algorithms applied should compare changes in volume at Hospital ABC to net change in volume for the other hospitals serving the market.

Hospital ABC for Service Area	**Aggregate of Other Hospitals for Service Area**	**Market Share Adj. for Hospital ABC**
Volume Increase	Volume Increase	No
Volume Decrease	Volume Decrease	No
Volume Increase	Volume Decrease	**Yes - Increase:** Hospital ABC increase = The lesser of the increase at ABC or the net aggregate decrease at other hospitals with patients from the service area. **Example 1:** ABC = +40 Rest of Area = -30 Market Share Adjustment of 30 cases to ABC. **Example 2:** ABC = +40 Rest of Area = -70 Market Share Adjustment of 40 cases to ABC.

Principles for Market Share Adjustments under Global Revenue Models

Hospital ABC for Service Area	Aggregate of Other Hospitals for Service Area	Market Share Adj. for Hospital ABC
Volume Decrease	Volume Increase	**Yes – Decrease:** Hospital ABC Decrease = Lesser of decrease in cases at ABC or net aggregate increase at other hospital serving patients from the service area. **Example 1:** ABC= -40 Rest of Area= +50 Market Share Adjustment of 40 cases from ABC **Example 2:** ABC= -40 Rest of Area= +30 Market Share Adjustment of 30 cases from ABC

Legislative Update

The Legislative Update will be presented at the Commission Meeting

State of Maryland
Department of Health and Mental Hygiene

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Herbert S. Wong, Ph.D.
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Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **February 4, 2015**

RE: **Hearing and Meeting Schedule**

March 11, 2015	Time to be determined, 4160 Patterson Avenue HSCRC/MHCC Conference Room
April 15, 2015	Time to be determined, 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://www.hscrc.maryland.gov/commission-meetings-2015.cfm

Post-meeting documents will be available on the Commission's website following the Commission meeting.