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Introduction

Market Share Adjustments (MSAs) are part of a much broader set of tools that link global budgets to populations and patients under the State's new All Payer Model. MSAs can play a role in improving customer service and high quality care and are central to ensuring that revenue is appropriately reallocated when shift in patient volumes occur between hospitals. A broader concept of market share includes shifts to unregulated health care space, which would require access to data outside of current HSCRC data sets. The measurement strategy and guiding principles can be applied to any market shift regardless of site of service, i.e. to another hospital or to unregulated services.

The purpose of MSAs is to provide a basis for increasing or decreasing the Approved Regulated Revenue (ARR) of Maryland hospitals operating under Global Budget Revenue (GBR) rate arrangements to recognize the movement of patients. Ideally, MSAs would support the promotion of greater value throughout Maryland hospital system. An MSA under a global budget revenue system is 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 market share 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.

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 them maximum extent practicable and or results in demonstrably higher quality.

The MSA should not hinder the global budget incentive to eliminate marginal services that do not add value, are unnecessary or do not reduce utilization resulting from better 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.

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

Examples of reductions in utilization that undermine the achievement of the Triple Aim are those that result from:

- Measures such as marketing strategies, inducements in physician contracts, limiting availability of emergency room care designed to prompt patients with unprofitable service needs to seek care elsewhere;
- Reducing volume or capacity to the point of creating long waiting lists or delays;
- Underinvesting in new technology or modes of care proven to be efficient ways of improving patient health, safety or quality;
- Structuring a hospital's overall service mix to reduce the volume of non-profitable services below the amount needed by patients within the hospital's service area;
- Reducing total level of a hospital's medical staff or the quality of affiliated providers to the point of compromising patient care; or
- Undermining patient care by providing care in settings outside the hospital when patients would be better served within the hospital; providing lower-cost services within the hospital when more costly services would better meet patient needs; or delaying the onset of hospitalization for particular patients in ways that place health at risk.

Similarly, the MSA together with other mechanisms and policies must distinguish between increases in utilization at any given hospital that should be recognized and rewarded and those that should not be recognized or rewarded. For example, a hospital should receive an increase in its ARR is when organizations such as Health Maintenance Organizations, Medicaid Managed Care Organizations, Accountable Care Organizations, or Primary Care Medical Homes channels their members from low value to high value hospitals to improve efficiency, cost-effectiveness and quality. Hospitals should also receive increases to their ARR in circumstances result in a shift of patient volumes but 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. On the other hand, increases in volume that are not related to achieving the

Triple Aim and that are within the hospital's control, such as the result of hospitals pursuing a strategy of acquiring physician practices for increased referrals or a redirection of services to their facilities unrelated to improved value, should not be encouraged.

Guiding Principles

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

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.

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 expected 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 A to net change in volume for the other hospitals serving the market.

Hospital A for Service Area	Aggregate of Other Hospitals for Service Area	Market Share Adj. for Hospital A
Volume Increase	Volume Increase	No
Volume Decrease	Volume Decrease	No
Volume Increase	Volume Decrease	Yes - Increase Hospital A Increase > Absolute Value of Decrease at Other Hospitals: Shift = Decrease at Other Hospitals Hospital A Increase < Absolute value of Decrease at Other Hospitals: Shift = ABC Increase
Volume Decrease	Volume Increase	Yes – Decrease Absolute Value of A Decrease > Increase at Other Hospitals: Shift = Increase at Other Hospitals Absolute Value of Hospital A Decrease < Absolute value of Increase at Other Hospitals: Shift = A Decrease