



**All Payer Hospital System Modernization
Payment Models Workgroup**

Meeting Agenda

June 30, 2016

9:30 am to 11:30 am

Health Services Cost Review Commission

Conference Room 100

4160 Patterson Avenue

Baltimore, MD 21215

- I. Introductions and Meeting Overview
- II. Psych/ Mt. Washington Update Amount
- III. Measuring Success
 - Final Recommendation
 - Cost Trends
 - Performance Measurement Dashboards
- IV. Update on Access to Medicare Data
- V. GBR Agreement Update
 - TPR Hospital Agreements
- VI. Market Shift Adjustment Update
- VII. Commission Meeting Schedule Update
 - Draft Jobs Program
 - Draft Psych and Mt. Washington Update

**ALL MEETING MATERIALS ARE AVAILABLE AT THE MARYLAND ALL-PAYER HOSPITAL
SYSTEM MODERNIZATION TAB AT HSCRC.MARYLAND.GOV#**

REVISED RECOMMENDATIONS FOR RY 2017 BALANCED UPDATE

The final recommendation for psychiatric hospitals and Mt. Washington Pediatrics is as follows and is offered conditioned on the adoption by the Commission of other policy recommendations of staff that affect the overall targets.

1. Release the productivity adjustment of 0.50 percent. This results in a new net amount of 2.05 percent, which can be reviewed in the chart below.

	Psych & Mt. Washington Revenues
Proposed Base Update	2.80%
ACA Adjustment	-0.75%
Proposed Update	2.05%

2. In addition to receiving a higher update amount, these hospitals must agree to the following:
 - a. HSCRC staff will begin to implement quality measures and value based programs for psychiatric facilities/beds beginning in RY18. In order to successfully capture appropriate metrics, staff requests the following from the hospitals:
 - i. Work with HSCRC staff to compile a list of Potentially Avoidable Utilization metrics and readmissions reduction targets. These may include measures to reduce high risk Medicare readmissions by ensuring satisfactory discharge plans and availability of outpatient services;
 - a. Partner with community-based mental health services to improve care coordination and reduce potentially avoidable utilization;
 - b. Improve access to community-based mental health services;
 - ii. Work with CRISP, HSCRC, and MHA to obtain available information to support monitoring and implementation efforts;
 - iii. Work with CRISP, HSCRC, and CMMI to obtain data for care redesign activities as soon as it is available;
 - iv. Monitor the growth in Medicare’s total cost of care and total hospital cost of care for its service area;
 - v. Implement programs focused on complex and high needs patients with multiple chronic conditions, initially focusing on Medicare patients;

- vi. Work with CRISP to exchange information regarding care coordination resources aimed at reducing duplication of resources, ensuring more person-centered approaches, and bringing additional information to the point of care for the benefit of patients and
- vii. Increase efforts to work in partnership with physicians, post-acute and long term facilities, and providers to create aligned approaches and incentives to improve care, health, and reduce avoidable utilization for the benefit of patients. Work with physicians with the goal of developing and enhancing value-based approaches that are applied under MACRA.

DRAFT FOR DISCUSSION

REVISED RECOMMENDATIONS FOR RY 2017 BALANCED UPDATE

Update Requirement	Aim	Requirements/Measures
Agree to Mid-Year target that is .56% lower than annual target.	Ensure charges are lower in CY 2016 and that progress is being made	Amend GBR Agreement to add Penalties for overcharges on mid-year targets
Monitor the growth in Medicare’s total cost of care and total hospital cost of care for its service area;	Reduce growth in Medicare’s costs	Review monthly reports from HSCRC/CRISP for service area Prepare and review monthly hospital reports for Medicare charge growth and Medicare ECMAD growth, compared to the prior year, removing overcharges from the prior year Target growth rate lower than 0% Medicare charge growth for CY 2016 over CY 2015. December was low in CY 2015, so need to build cushion.

Update Requirement	Aim	Requirements/Measurements
Work with CRISP, HSCRC, and MHA to obtain available information to support monitoring and implementation efforts;	Gain access to LDS files and to plan and implement care interventions and monitor results	File letter of intent to evaluate participation in care redesign amendment There are public use files already available
Work with CRISP, HSCRC, and CMMI to obtain data for care redesign activities as soon as it is available;	Gain access to claims level detail data for care redesign—risk stratification, claims level monitoring, etc.	Participate in one or more aspects of care redesign amendment. No requirement to participate in gainsharing—this is optional
Monitor the hospital’s performance on PAUs for both Medicare and All Payers.	Reduce PAUs to achieve better care and AIM of demonstration Year over year declining percentages of PAU.	Include current definitions + also include all medical admissions through ER

Update Requirement	Aim	Requirements/Measurements
<p>Implement programs focused on complex and high needs patients with multiple chronic conditions, initially focusing on Medicare patients;</p>	<p>Implement programs for ~ 25,000 high risk and 80,000 rising risk Medicare beneficiaries</p> <p>Patients are receiving better system supports, admissions and ER visits are reduced</p>	<p>Select complex and high needs patients for ongoing care management and other interventions</p> <ul style="list-style-type: none"> • Start with complex, using PaTH or other resources (25,000 benes) • Use Medicare claims data, EMRs and other resources to enhance selection processes <p>Count patients with health risk assessment, care plan, and assigned care manager that have been reported to CRISP</p>
<p>Work with CRISP to exchange information regarding care coordination resources aimed at reducing duplication of resources, ensuring more person centered approaches, and bringing additional information to bear at the point of care for the benefit of patients</p>	<p>Ensure beneficiaries do not have duplicate resources and that MACRA requirements for electronic health records and information exchange are being met</p> <p>Person centered care</p>	<p>Populate care plans, care overviews, consents, health risk assessments, and assigned case managers</p> <p>Work with CRISP to identify any duplication and inter-hospital reconciliation process</p> <p>Continue work with regional partners to develop approaches to eliminate duplication and ensure person centeredness</p> <p>Sign amendment to GBR agreement that meets MACRA specifications (see below)</p>

Update Requirement	Aim	Requirements/Measurements
<p>Increase efforts to work in partnership with physicians, post-acute and long term facilities, and other providers to create aligned approaches and incentives to improve care, health, and reduce avoidable utilization for the benefit of patients. Work with physicians with the goal of developing and enhancing value based approaches that are applied under MACRA (Medicare Access and CHIP Reauthorization Act of 2015);</p>	<p>Reducing avoidable admissions from assisted living and long term care, readmissions from SNF, and SNF LOS</p> <p>Reducing avoidable hospitalizations with primary care and other community providers</p>	<p>Work with MHA, HSCRC, and non-hospital partners to specify priority programs for CY 17, CY 18, etc.</p>
<p>Participate in the All Payer Model progression planning efforts</p>	<p>Evaluate approaches and make recommendations to progress toward increased capability to take on additional responsibilities</p> <p>-Help develop models around medical homes, ACOs, geographic models</p>	<p>Work with DHMH, HSCRC, and MHCC in planning progression</p>

1. The Commission should continue to closely monitor performance targets for Medicare, including Medicare's growth in Total Cost of Care and Hospital Cost of Care per beneficiary. As always, the Commission has the authority to adjust rates as it deems necessary, consistent with the All Payer Model.
 - a. Targets should be monitored both state-wide and on a hospital specific level.
 - b. If corrections become necessary, the Commission should consider whether to make the corrections based on hospital specific performance.

HSCRC WILL WORK TO PRODUCE MONITORING OF PROGRESS ON REDUCING PAUS AS WELL AS ADMISSIONS AND ER VISITS FOR MEDICARE PATIENTS AND HOSPITAL AND TCOC IN COUNTIES AND SERVICE AREAS. MIMIMUM TARGETS IN THE TESTS ARE FOR DETERMINING FAILURE. THE ALL PAYER MODEL AIMS TO DEMONSTRATE THAT WE CAN REDUCE AVOIDABLE UTILIZATION AND IMPROVE CARE FASTER THAN THE NATION. ASPIRATIONAL TARGETS WILL REACH COST GOALS.

2. In order to receive the full update for FY 18, hospitals will need to reduce Potentially Avoidable Utilization and any excess increases in Medicare's non-hospital costs resulting from implementation and will need to be at least offset by reductions in Medicare's hospital costs.

WITH CONCENTRATED INCREASE IN JANUARY THROUGH JUNE, THIS WILL ADD PERFORMANCE CHALLENGES FOR CY 17. HOSPITALS HAVE ARGUED THAT ADDITIONAL TIME WILL YIELD REDUCTIONS IN MEDICARE UTILIZATION AND COST. IF THIS DOES NOT HAPPEN, CY 18 RATES WILL NEED TO BE CONSTRAINED.

This will be included in a GBR amendment for MACRA to include EHR requirements:

CEHRT (Certified Electronic Health Record Technology)

Hospital and any Care Redesign Participants must:

Use CEHRT to document and/or communicate clinical care to their patients or other health care providers.

(pg 738, §414.1415 Advanced APM criteria)

Hospital has CEHRT technology implemented.

MIPS eligible clinician reports clinical quality measures (CQMs) using certified EHR technology under the quality performance category (pg 195, Section 1848(o)(2)(A)(iii)). For 2017, MIPS eligible clinicians would be able to use EHR technology certified to either the 2014 or 2015 Edition certification criteria (pg 200)

Attestation requirements related to health information exchange and information blocking from all eligible clinicians under the advancing care information performance category of MIPS, including eligible clinicians who report on the advancing care information performance category as part of an APM Entity group under the APM Scoring Standard (an EP, eligible hospital, or CAH under the Medicare and Medicaid EHR Incentive Programs) must attest to this three-part attestation (pg 43 – 44)

1. did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology
2. that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times: connected in accordance with applicable law; compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170; implemented in a manner that allowed for timely access by patients to their electronic health information; (including the ability to view, download, and transmit this information) and implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 USC 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors
3. responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 USC 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor

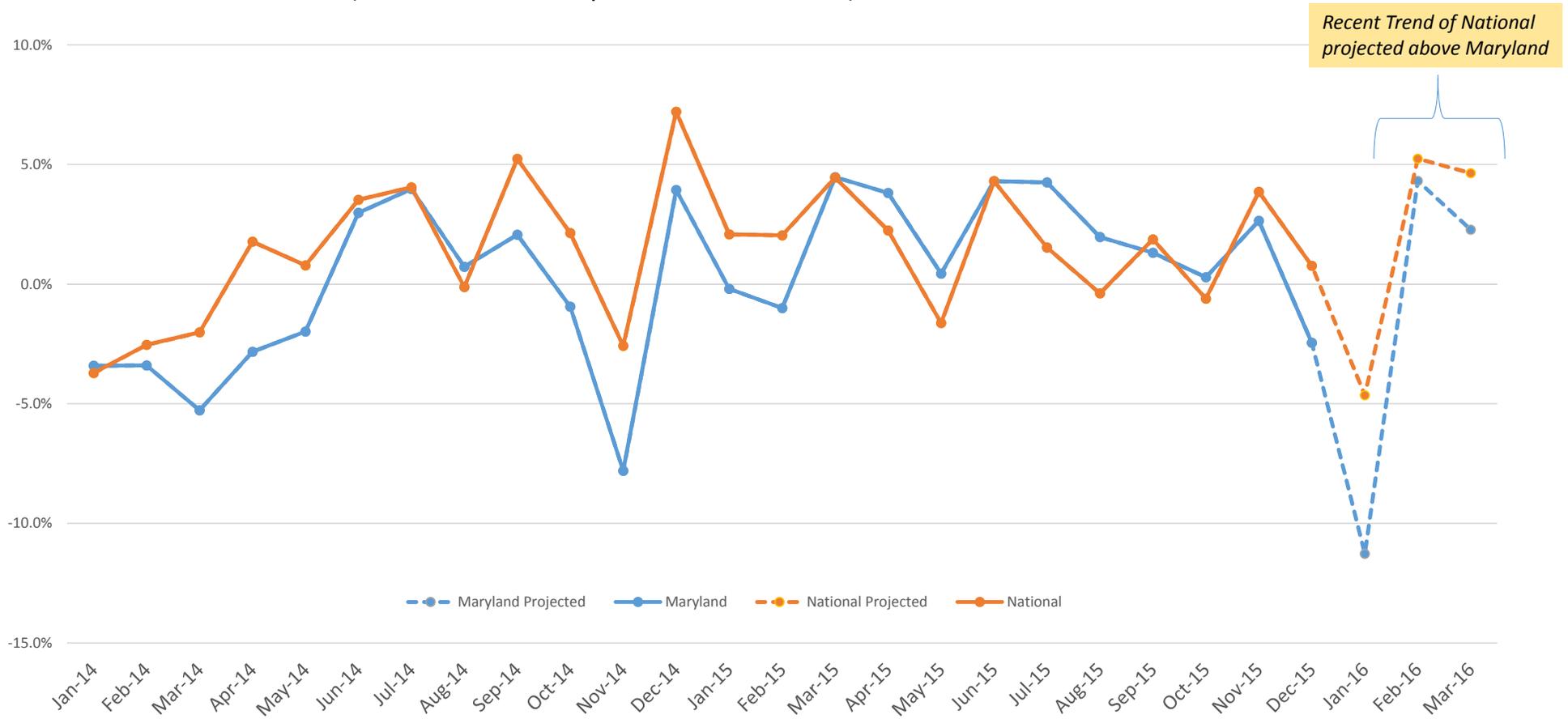
Hospital & TCOC Spending per Beneficiary

Disclaimer

Data contained in this document represent analyses prepared by MHA and HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

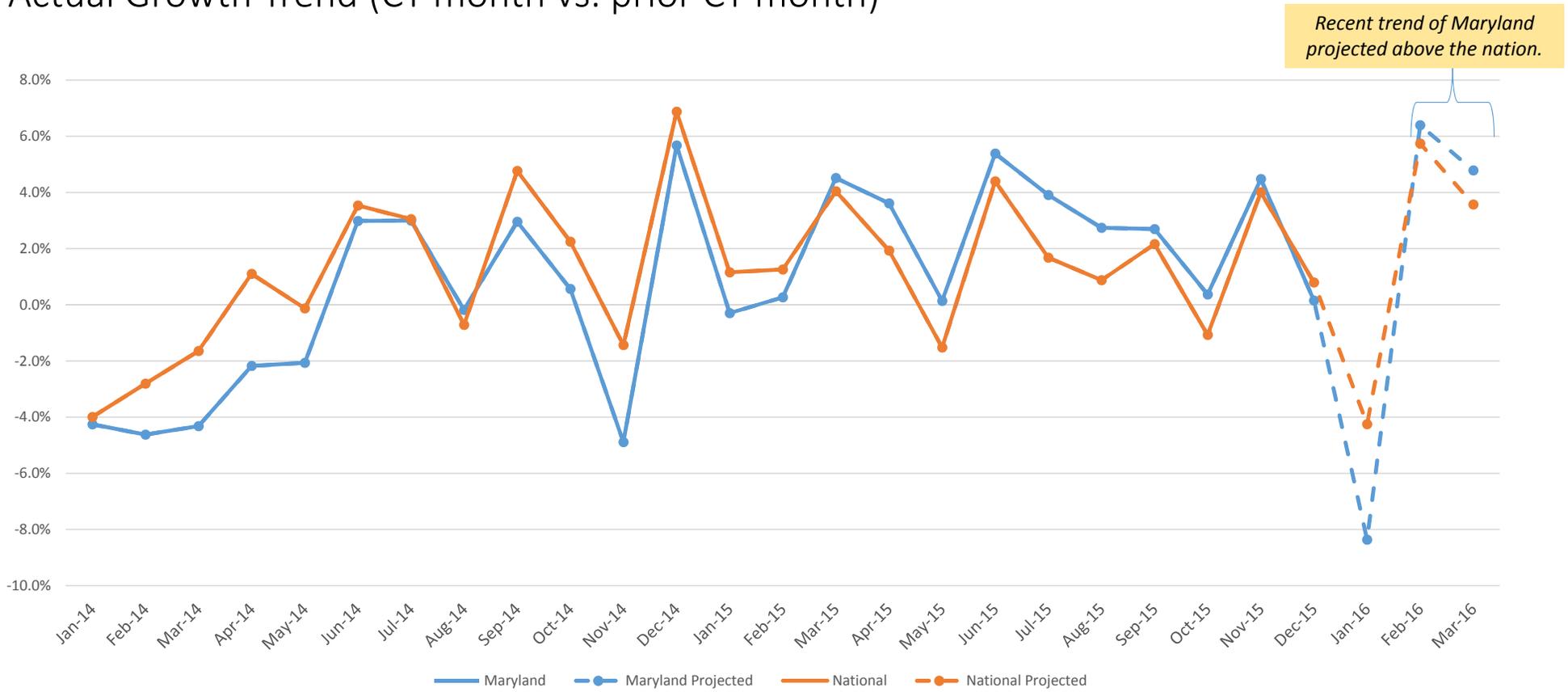
Monthly Total Hospital Spending per Medicare Beneficiary

Actual Growth Trend (CY month vs. prior CY month)



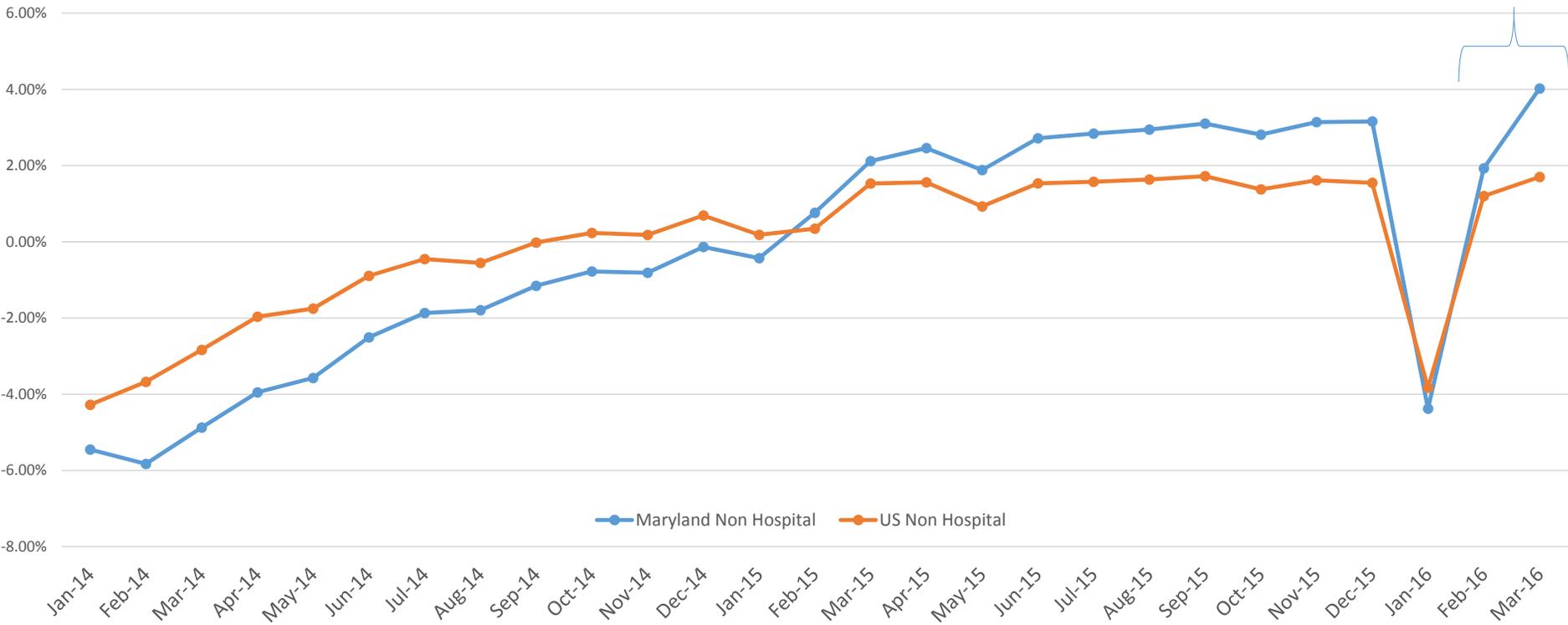
Monthly Total Spending per Medicare Beneficiary

Actual Growth Trend (CY month vs. prior CY month)

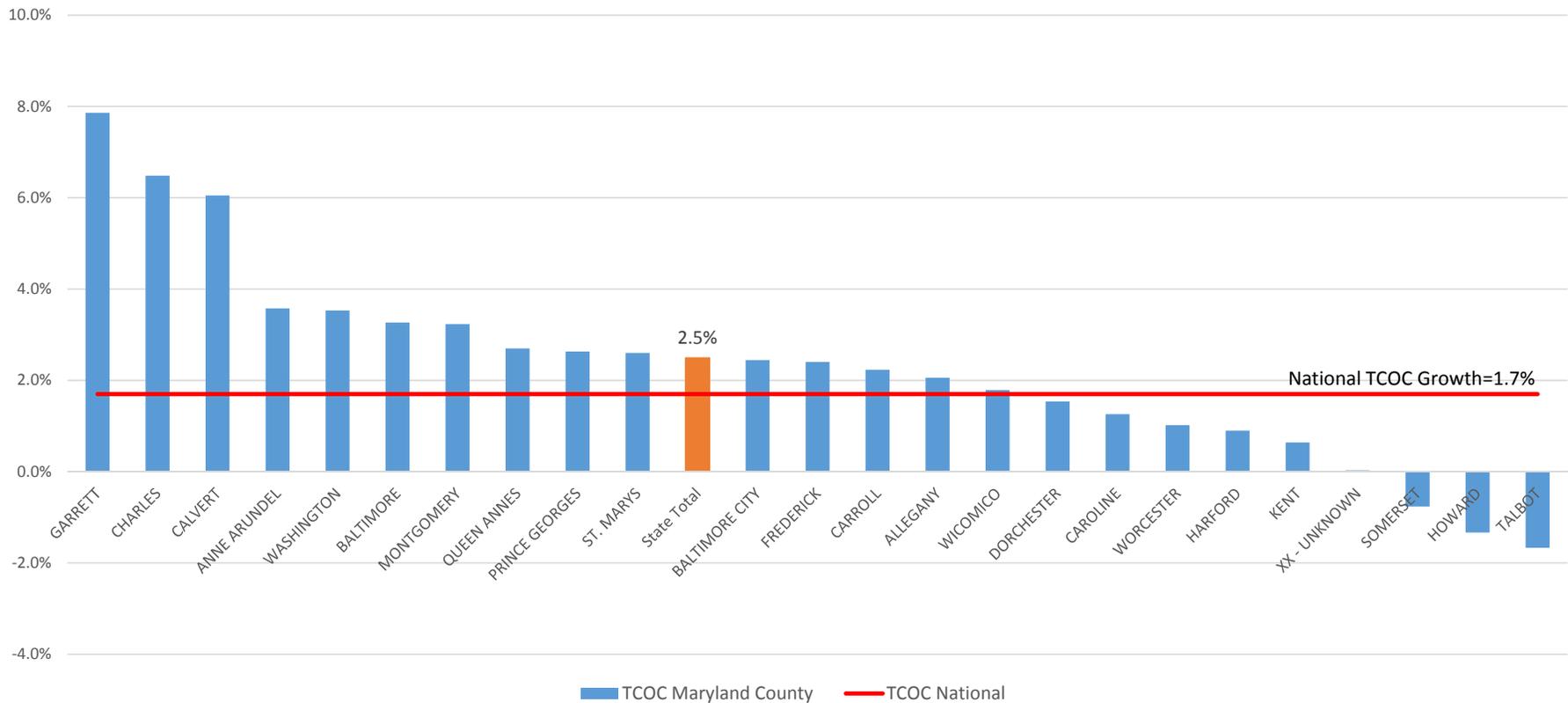


Monthly Non-Hospital Spending per Medicare Beneficiary Actual Growth Trend (CY month vs. prior CY month)

Recent trend of Maryland projected above the nation.



Medicare Total Spending per Beneficiary Growth By County: CY 2014 – CY 2015 (Maryland vs National)



Source: Geographic Variation File, 2011-2015, created by CMS for HSCRC



CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

CRISP Reporting Services

Report to HSCRC Payment Workgroup

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June 30, 2016

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CRISP Services

Clinical Query Portal

- Patient information accessible at the point of care, including: lab results, radiology reports, PDMP, discharge summaries, and more

Encounter Notification Service (ENS)

- Real-time hospital admission, discharge, and transfer notifications available to providers who submit a patient list
- Auto-subscriptions for hospitals to receive alerts for readmissions within 30-days across Maryland, DC, and Delaware hospitals

CRISP Reporting Services (CRS)

- Reporting and analytic tools to support patient identification, care coordination, and performance measurement



CRISP Methods for Reporting

Portal

- Internet-based
- Distributes static reports, includes archived reports
- Evolved from emailing users
- In use for over 3 years
- Patient-level data
- Target audience: Hospital Admin

The screenshot shows the 'CRISP Reporting Service Portal' interface. At the top left is the CRISP logo. The main heading is 'CRISP Reporting Service Portal'. Below this is a 'Reports' section with a navigation bar containing 'Reports', 'Holy Cross System', and '210065 HCH_GT'. A list of reports is displayed, including 'Archive', 'Patient Level Details', and several user guides and readmission reports for RY16 and RY17.

Dashboards

- Internet-based
- Separate entry point from Portal, shared credentialing
- Aggregated data and patient level data for care coordination
- Portals for Hospitals, Ambulatory Providers, and Populations

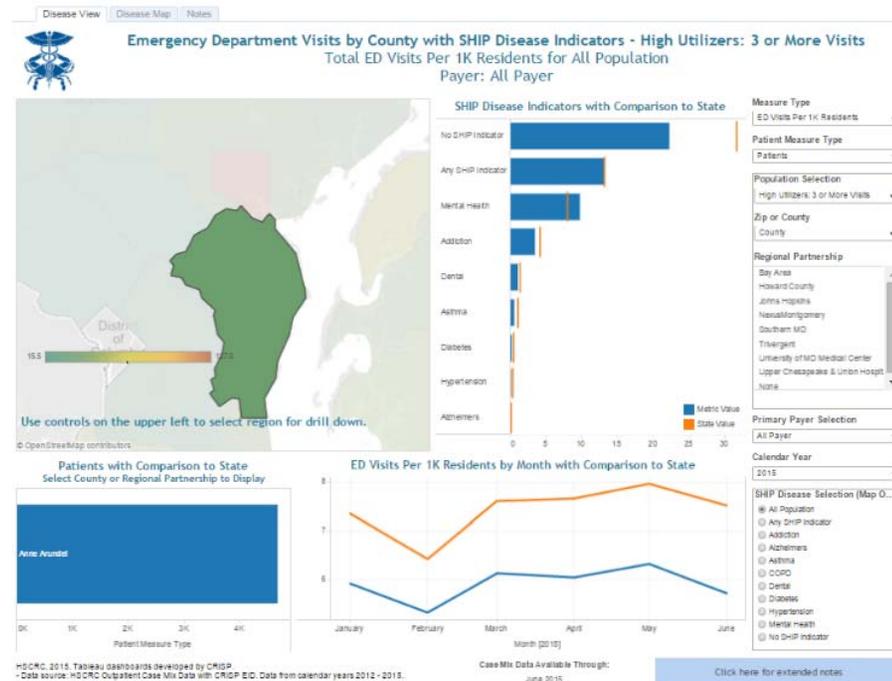
The screenshot shows the 'CRISP Reporting Services' dashboard for the 'Hospital Reporting Portal'. The header includes the CRISP logo and the text 'CRISP Reporting Services Connecting Providers with Technology to Improve Patient Services'. The dashboard features a large blue graphic on the left and a central area with icons for 'Patient Total Hospitalizations (Patis)', 'Chronic Conditions', 'Populations', 'Potentially Avoidable Illnesses (PAI)', and 'Total Cost of Care'. The CRISP logo is prominently displayed on the right, with the text '11 reports available' below it. At the bottom, contact information for CRISP is provided.



New Reporting and Analytics Tools

- The CRS team is enhancing the care network infrastructure for reporting and analytics
- Developing tools and information to support:

1. High-Risk Patient Identification
2. Regional Coordination and Planning
3. Performance Measurement





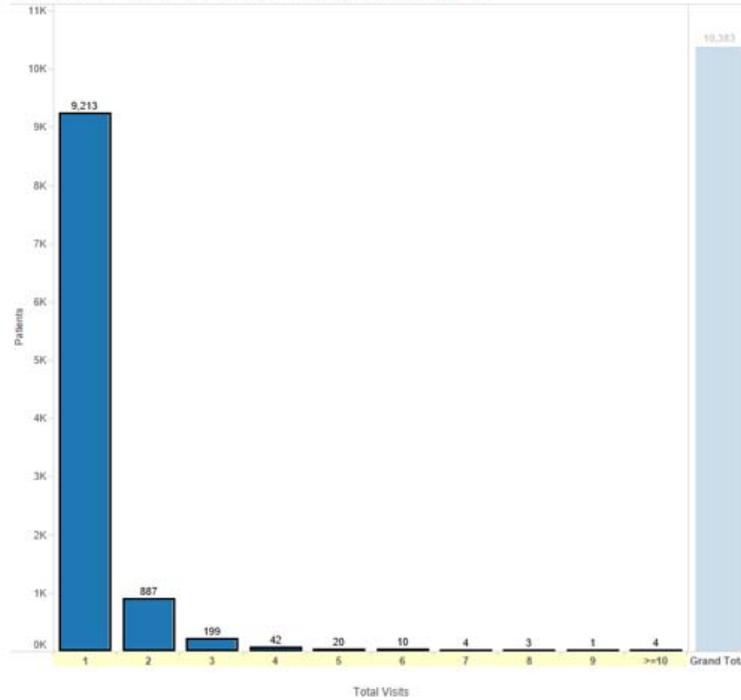
PaTH Summary View



Patient Total Hospitalizations Summary - Patients by Number of Visits All Population

Last 3 Months Patients by Total Number of Visits

Select one or multiple bars from top to bottom to view total visits at all hospitals



Hospital Name

Time Period
Last 3 Months

Total Charges
All values

Total Visits
All values

Readmissions
All values

Ambulatory ER Visits
All values

Bedded Care (IP + Obv) >=24 hrs
All values

MRN

Zip on Recent Visit

Primary Payer
All

Secondary Payer
Multiple Values

Age Group
All

High Utilizers
Across All Hospitals
All Population

Conditions

Chronic

- Asthma
All
- COPD
All
- Chronic Kidney Disease
All
- Diabetes
All
- Heart Failure
All
- Hyperlipidemia
All
- Hypertension
All
- Mental Health
 - Alzheimers/Other Dementia
All
- Depression
All
- Oncology
 - Colorectal Cancer
All
 - Endometrial Cancer
All
 - Female/Male Breast Cancer
All
 - Lung Cancer
All
 - Prostate Cancer
All
- Other
 - Anemia
All
 - Atrial Fibrillation
All
 - Hip/Pelvic Fracture
All
 - Ischemic Heart Disease
All
 - Osteoporosis
All
 - Stroke/Transient Ischemic Attack
All

Last 3 Months Total Visits and Charges Across All Hospitals



HSCRC, 2015. Tableau dashboards developed by CRISP
- Data source: HSCRC Inpatient and Outpatient Case Mix Data with CRISP EID. Data from calendar years 2014 - 2015.

Case Mix Data Through
June 2015

[Click here for extended notes](#)

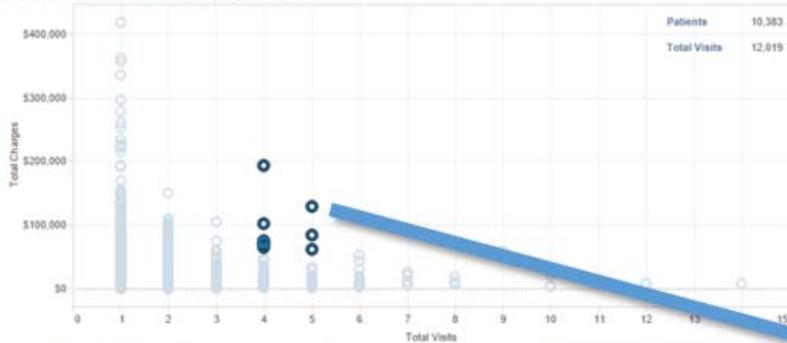


PaTH Patient-Level Details



Patent Total Hospitalizations Dashboard - Patients by Visits and Charges All Population

Last 3 Months Patients by Visits and Charges
Select one or more bubbles to view patient details



Hospital Name

Time Period
Last 3 Months

Patients 10,383
Total Visits 12,019

Utilization

Total Charges
All values

Total Visits
All values

Readmissions
All values

Ambulatory ER Visits
All values

Days in Hospital (IP + Obs) > 24 hrs
All values

MRN

Zip Recent

Primary Payer
All

Secondary Payer
Multiple Values

Age Group
All

High Utilizers
Across All Hospitals
All Population

Conditions

Chronic

- Asthma All
- COPD All
- Chronic Kidney Disease All
- Diabetes All
- Heart Failure All
- Hyperlipidemia All
- Hypertension All

Mental Health

- Alzheimers/Other Dementia All
- Depression All

Oncology

- Colorectal Cancer All
- Endometrial Cancer All
- Female/Male Breast Cancer All
- Lung Cancer All
- Prostate Cancer All

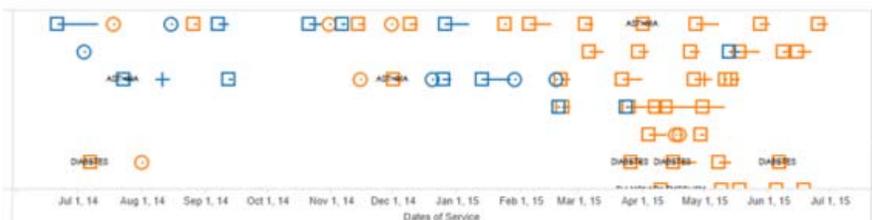
Other

- Anemia All
- Atrial Fibrillation All
- Hip/Pelvic Fracture All
- Ischemic Heart Disease All
- Osteoporosis All
- Stroke/Transient Ischemic Attack All

Last 12 Months Patient Details:

EID	Current Hospital							All Hospitals Total		
	Total Charges	Total Visits	Visits IP	Visits OBV	Visits ER	Bedded Care	Age	Total Charges	Total Visits	Total Hospitals
\$158,466	13	10	0	3	10	50		\$253,788	19	2
\$157,889	6	6	0	0	6	72		\$167,893	8	2
\$86,795	8	6	1	1	7	53		\$147,757	16	3
\$78,282	5	5	0	0	5	57		\$86,052	7	2
\$70,551	4	2	0	2	2	23		\$70,551	4	1
\$82,009	6	5	0	1	5	58		\$82,009	6	1
\$83,505	5	5	0	0	5	29		\$83,505	5	1
\$192,912	4	3	0	1	3	24		\$358,551	6	2
\$102,064	4	3	0	1	3	25		\$102,064	4	1

Last 12 Months Patient Hospital Utilization Timeline Across All Hospitals
Select EID to view hospitalizations details



Patient Total Hospitalizations - Patient Detail Sorted by Admit Date
Inpatient, Observation, and Emergency Department Services at All Hospitals

Hover over More link on the right to view diagnoses description

Id#	IP	Re	type	admit	Pg	DRG	DRG Description	SOI	Dx1>Description	Dx1	Dx2	Dx3	Dx4	More
1	Yes	141	ASTHMA	2			"ASTHMA W/ACUTE EXACERBATION (Begin 2008)"	49392	V482	24900	V8542			More
1	Yes	148	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	3			"ASTHMA W/ACUTE EXACERBATION (Begin 2008)"	49322	V146	V141	V1587			More
1	Yes	141	ASTHMA	2			"ASTHMA W/ACUTE EXACERBATION (Begin 2008)"	49392	4280	V85	25000			More
1	Yes	720	SEPTICEMIA & DISSEMINATED INFECTIONS	2			"STAPH SEPTICEMIA, UNSPEC (Begin 1987)"	61810	486	49320	78802			More
1	Yes	148	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	4			"CH OB ASTHMA W/ STAT ASTH (Begin 1988)"	49321	5849	4821	9341			More
1	Yes	347	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	2			"PATH FX/VERTEBRAE (Begin 1993)"	73113	4280	V85	2768			More
1	Yes	721	POST-OPERATIVE POST-TRAUMATIC, OTHER	4			"INFECT DT CENT VEN CATH (Begin 2007)"	99921	51881	5845	2762			More
1	Yes	248	NONBACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	3			"INFECTIOUS ENTERITIS NOS"	0090	4280	V85	73113			More
1	Yes	140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	3			"CH OB ASTHMA W/ACUTE EXACERBATION (Begin 2009)"	49322	4280	V462	8054			More
1	Yes	140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	3			"CH OB ASTHMA W/ACUTE EXACERBATION (Begin 2009)"	49322	51881	4280	27801			More

HSCRC, 2015. Tableau dashboards developed by CRISP.
Data source: HSCRC Inpatient and Outpatient Case Mix Data with CRISP EID. Data from calendar years 2014 - 2015.

Click here for extended notes



Medicare High Utilizers

Purpose is to allow hospitals to view Medicare high utilizers of inpatient services and gather enough information to make care management decisions

- High utilizer = 3 or more bedded care admissions (IP and Obs >24hrs) in 12 months
- Information included: hospitals visited, dates, subscribed panels, utilization counts, chronic conditions



Patient Total Hospitalizations Dashboard - High Utilizer Medicare FFS High Utilizers During the Last 12 Months

Hospital Name
March 2015 - February 2016

Hospital MRN Hospital1 Hospital2 Hospital3 Most Recent Hospital Discharge Date of Most Recent Discharge Panel Affiliation1 Panel Affiliation2 IP, OBV, ED Charges IP Visits OBV Visits ED Visits All Hospital IP, OBV, ... All Hospital IP Visits OB

Hospital Name
Hospital Name

Total Patients
925

Utilization at Current Hospital

IP Visits
All values

IP, OBV, ED Charges
All values

Utilization at All MD Acute Hospitals

of Chronic Conditions
All values

of Hospitals with Disc..
All values

IP Visits
All values

Readmissions
All values

IP, OBV, ED Charges
All values

Panel Status
All

Panels

Case Mix Data Through:
February 2016

Headers in Medicare High Utilizers Report				
Hospital MRN	Hospital1	Hospital2	Hospital3	Most Recent Hospital Discharge
Date of Most Recent Discharge	Panel Affiliation1	Panel Affiliation2	IP, OBV, ED Charges	IP Visits
OBV Visits	ED Visits	All Hospital IP, OBV, ED Visits	All Hospital IP Visits	All Hospital OBV Visits
All Hospital ED Visits	All Hospital Re-admissions	Count of Hospital with Discharges	Number of Panels	Number of Chronic Conditions



Key Metrics Sample

HSCRC Key Metrics

Hospital

Time Frame

Custom Date Range

MHA Region:

Start Time

End Time

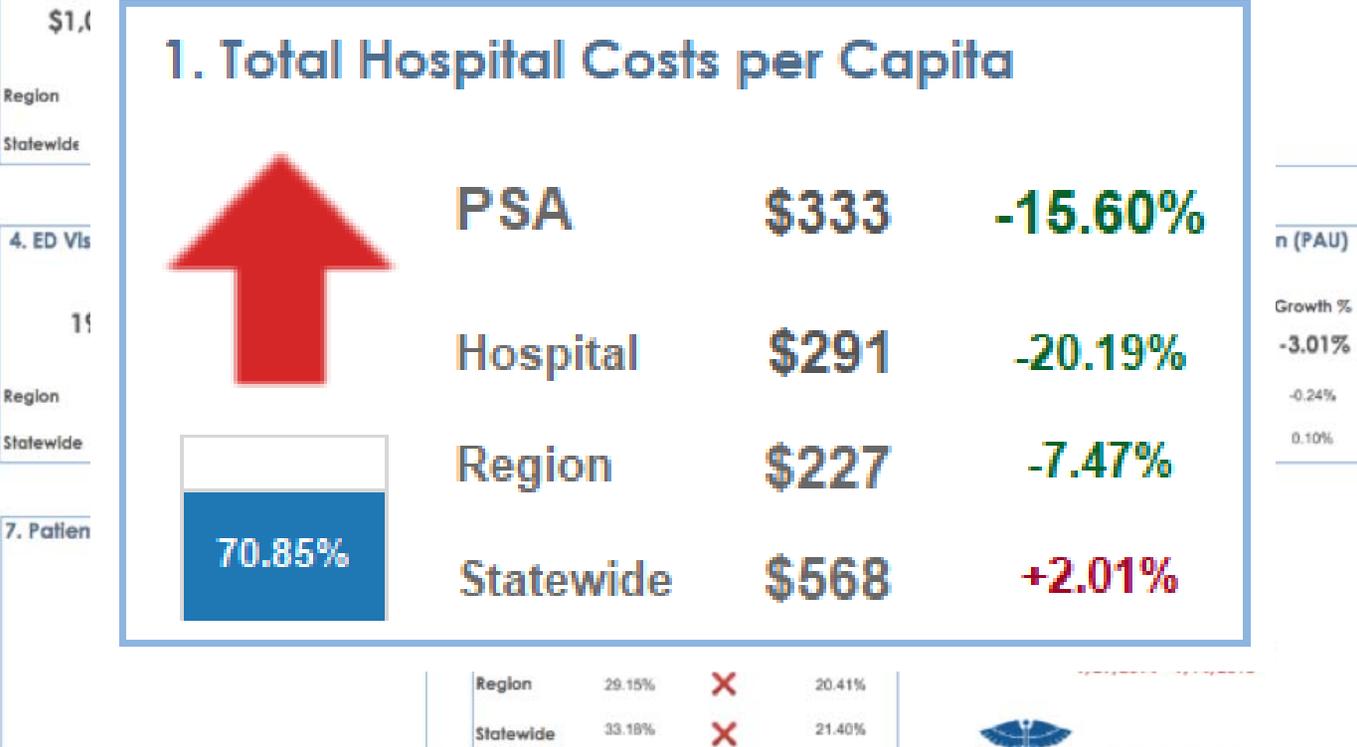
01/15/2015

12/31/2015

1. Total Hospital Costs per Capita

2. Total Hospital Discharges per 1000

3. Total Health Care Cost



Data Available 1/1/2014 - 2/29/2016



CRISP
Reporting Services



Contacts:

Craig Behm, Director of Reporting and Analytics

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Cell: 410.207.7192

Email: craig.behm@crisphealth.org

Paul Cummings, Population Health Analyst

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Mobile: 443.380.3628

Email: paul.cummings@crisphealth.org

Contract Addendum to GBR & TPR Agreements

- ▶ Contract Addendum will include language that describes:
 - ▶ Overcharge penalties for mid year targets
 - ▶ Limit on charge increases or decreases to <10% on an interim basis
 - ▶ The conditions to receive increased inflation dollars
 - ▶ EHR Requirement: CEHRT (Certified Electronic Health Record Technology)



Market Shift Adjustments Update

Market Shift Adjustments

- ▶ Market shift adjustment should not undermine the incentives to reduce avoidable utilization
- ▶ Market shift adjustment should provide necessary resources for services shifted to another hospital
- ▶ Calculations are based on
 - ▶ 66 inpatient and outpatient service lines
 - ▶ Zip codes and county level
 - ▶ Excludes Potentially Avoidable Utilization
 - ▶ Hospital service line average charge per ECMAD**
 - ▶ 50% variable cost factor applied
- ▶ Staff send out preliminary results for outpatient oncology service lines

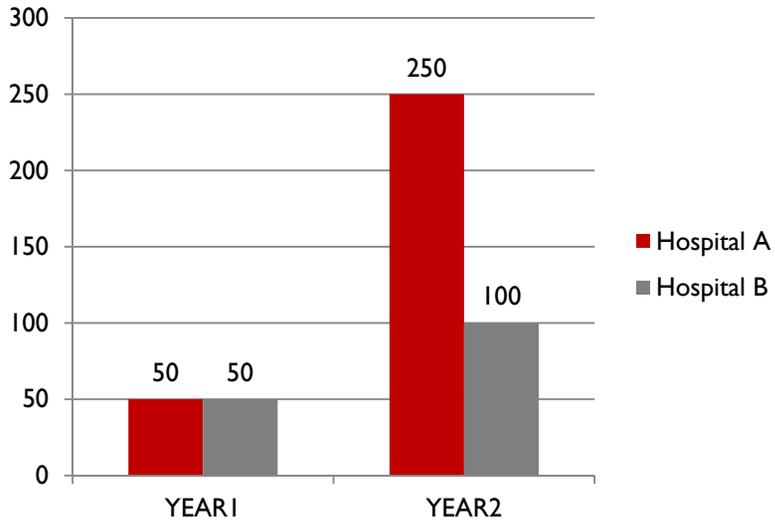
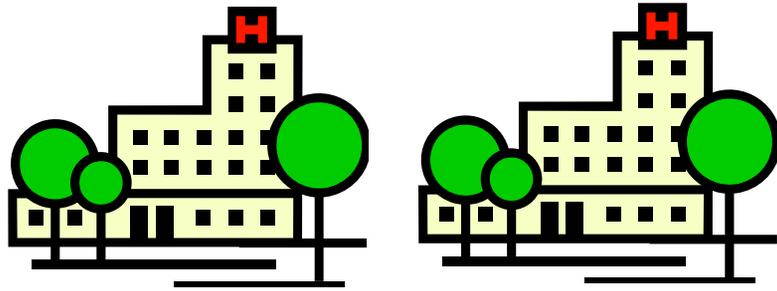
*AHRQ Prevention Quality Indicators

**Equivalent CaseMix Adjusted Discharges

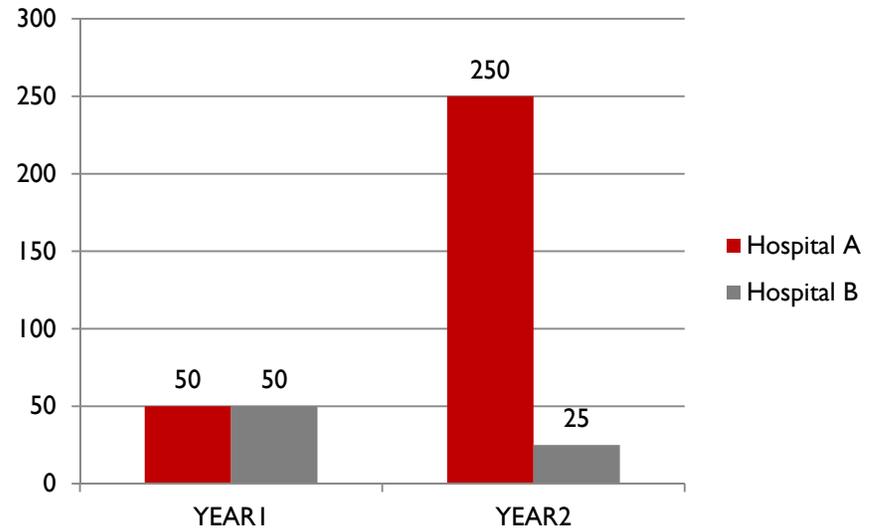
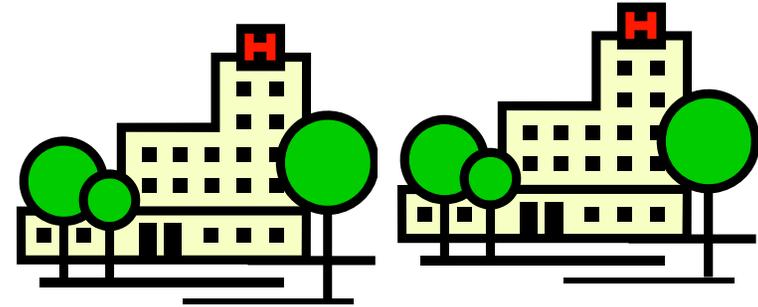
Market Share

vs.

Market Shift



Market Shift Adjustment=0



Market Shift Adjustment=25



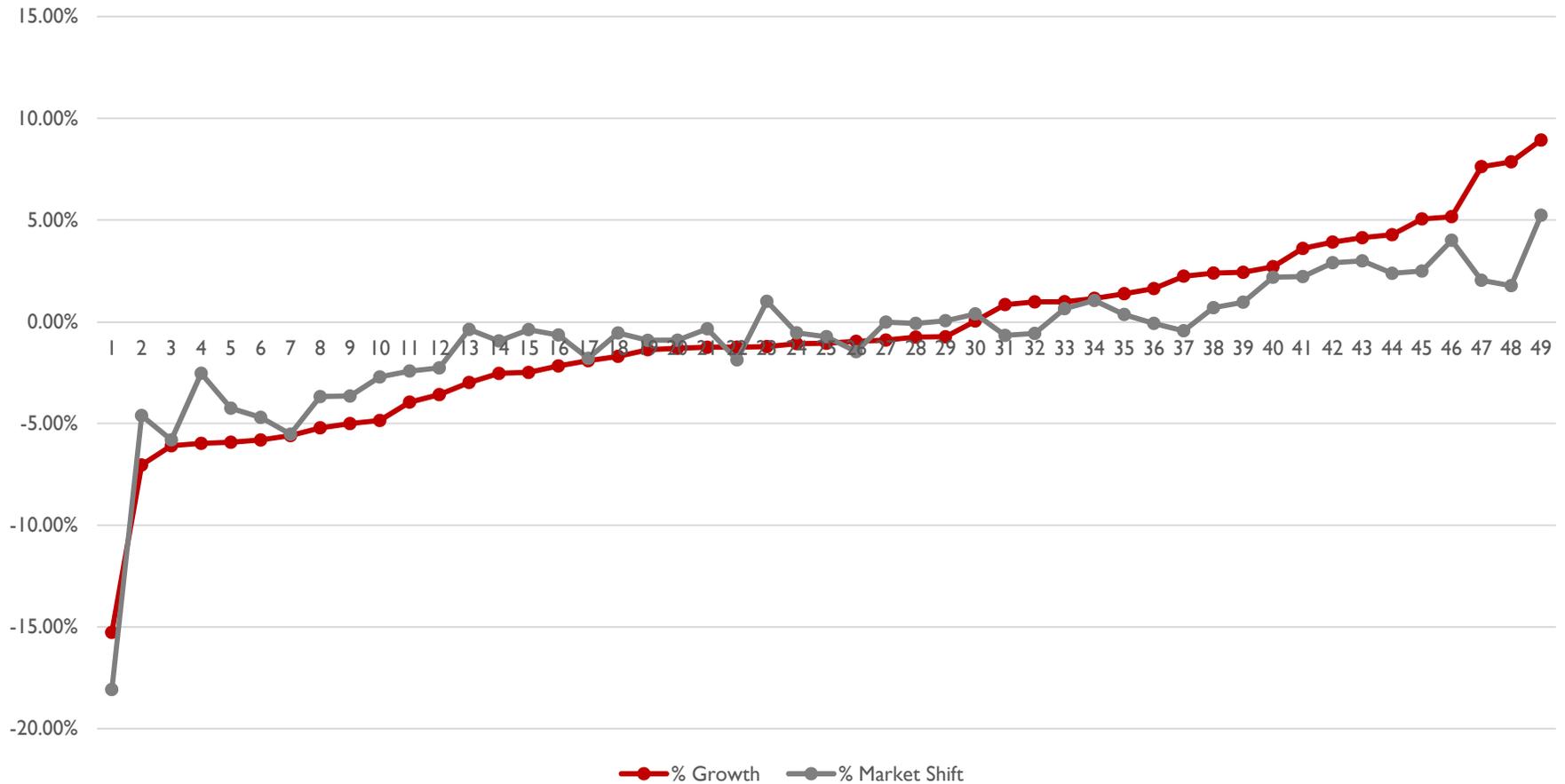
RY 2016 and FY 2017 Year to Date Statewide Impact*

Statewide Impact	FY 2016	FY 2017
A	B	C
Grand Net Total	-\$756,341	-\$5.7 mil
Positive Adjustment Total	\$27.7 mil.	\$53.6 mil.
Negative Adjustment Total	-\$28.5 mil.	-\$46,8 mil.
Absolute Adjustment as Percent of Total Charges in MSA	1.02%	0.98%

*excludes oncology/radiation therapy/infusion service line and other manual adjustments

Market shift adjustments and volume growth is more closely linked in the FY 2017 period

CY 2015 Volume Growth vs Market Shift Adjustments



Market Shift Updated for CY 2016

Measurement period

- ▶ **CY 2015** was based on an annual adjustment except for a few large market shift cases which was done mid-year
- ▶ **CY 2016** is moving to a semi annual adjustments
 - ▶ Jan-June 2016 period will be added to FY 2017 GBRs in January
 - ▶ Jan-December 2016 period will be reconciled and adjusted in FY 18 GBRs in July 2017.
- ▶ Any changes in hospital service provisions (closure of services, deregulation etc) are reflected immediately.
- ▶ **Service line updates for CY2016**
 - ▶ Add Sepsis cases to PAU exclusions
 - ▶ Alignment of inpatient and outpatient cases (cardiac procedures etc.)
 - ▶ Possible update to weight calculations