Principles for Market Share Adjustments under Global Revenue Models

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.

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 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 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 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 hospital without compromising patient care.

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

- Measures that are designed to prompt patients with unprofitable service needs to seek care elsewhere;
- 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;
- 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 the 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 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 channel 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:

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]

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:

[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.

- **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.
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