SUCCESSOR AGREEMENT BETWEEN THE HEALTH SERVICES COST REVIEW COMMISSION AND UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT DORCHESTER
REGARDING THE APPLICATION OF THE TOTAL PATIENT REVENUE SYSTEM

This Agreement made this 6th day of November, 2014, between UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT DORCHESTER (the "Hospital") and the MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (the "Commission" or "HSCRC") is subject to the following provisions:

# I. General Description

The Total Patient Revenue System ("TPR") is a revenue constraint system developed by the Maryland Health Services Cost Review Commission ("HSCRC") to provide hospitals with a financial incentive to manage their resources efficiently and effectively in order to slow the rate of increase in the cost of health care. The TPR also is consistent with the Hospital's mission to provide the highest value of care possible to the community it serves.

The TPR is available to sole community provider hospitals and hospitals operating in regions of the State characterized by an absence of densely overlapping services areas. The HSCRC staff reserves the right to exclude any hospital from eligibility for the TPR if it determines that that hospital's service area characteristics are not conducive to successful implementation and operation of the TPR.

The basic concept embodied in the TPR is the assurance of a certain amount of revenue each year, the Hospital's Approved Regulated Revenue, independent of the number of patients treated and the amount of services provided to these patients. The Hospital, therefore, has the incentive to reduce length of stay, ancillary testing, unnecessary admissions and readmissions, as well as improve efficiency in the provision of services while treating patients in a manner consistent with appropriate, high quality medical care.

# II. Methodology

### A. Revenue Covered by the Agreement and the Term of the TPR Agreement

The TPR Agreement will become effective July 1, 2013 and will have a term of three years covering the State fiscal years ("SFY") 2014, 2015, and 2016 (the Rate Years). The TPR Agreement will be applicable to all HSCRC rate regulated inpatient and outpatient services and revenue of the Hospital.

The Hospital has been subject to a prior TPR agreement that will end June 30, 2013 and be succeeded by this TPR Agreement. In each Rate Year, the Agreement will establish the Approved Regulated Revenue of the Hospital for the particular Rate Year, and the Approved Regulated Revenue, and associated Unit Rates for the Hospital will be set forth in the Hospital's Order Nisi for the particular Rate Year.

# III. Computation and Application of the TPR

### A. Compliance Monitoring Under the TPR

One of the goals of the TPR is to reduce the burden of regulation on hospitals. Thus, the HSCRC will

relax unit rate compliance corridors generally applied to hospitals. The Hospital will be free to charge at a level up to 5 percent above the approved individual unit rates without penalty. This limit can be extended to 10 percent for all rate centers at the discretion of the HSCRC staff upon presentation of evidence by the Hospital that it would otherwise not achieve the approved total revenue for the year. Similarly, there will also be a 5 percent corridor on undercharging. This corridor may also be expanded to 10 percent for all revenue centers if the Hospital can substantiate that the Hospital will exceed its revenue constraint without this flexibility.

**B. Calculation of Hospital Approved Regulated Revenue under TPR Constraint**

The Base Year of the Agreement is the SFY 2013. The Hospital's Approved Regulated Revenue in the Base Year will be defined as the Hospital's approved regulated revenue for the SFY 2013 computed in accordance with the TPR Agreement then in effect and all one time and permanent adjustments computed under that agreement.

In future years, the Hospital will be subject to rate adjustments necessary to bring it in compliance with the approved TPR Approved Regulated Revenue. If the gross revenue charged by the Hospital exceeds the approved revenue, the difference between the gross revenue charged and the approved revenue will be subtracted from the revenue that would otherwise have been approved for the Hospital for the subsequent year. Conversely, if the gross revenue charged is less than the approved revenue, the difference will be added to the revenue for the subsequent year, except that undercharges below the corridor specified in subparagraph A above will not be so included.

**C. Annual Adjustments**

The HSCRC shall apply the following adjustments to the Approved Regulated Revenue to arrive at the Approved Regulated Revenue for the subsequent year:

1. Adjustment for the annual update factor approved by the Commission;

2. Adjustment for any performance-based purchasing rewards, penalties, or scaling then applicable to the TPR hospitals[1]

3. Adjustment for population and demographic changes, the scope and data source(s) defined in Appendix B of this agreement.

4. Reversal of any previous retroactive adjustments, including those carried forward from the TPR agreement in effect for SFY 2013;

5. Differential readjustment due to changes in mix of payers or changes in approved differential amounts and bad debt;

6. Any required adjustment as specified in subparagraph B above between the Hospital's Approved Regulated Revenue and the Actual Revenue.

7. Compliance and Related Adjustments will be applied as a one time adjustment for overages or underages relative to the Hospital's Approved Regulated Revenue, as described in B above.

[1] This currently includes the Commission's Quality-Based Reimbursement and Maryland Hospital Acquired Conditions.

8. Any savings adjustments.[2]

**D. Other Adjustments**

1. The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services are shifted to an unregulated setting, HSCRC staff will calculate and apply a reduction in the Hospital's Approved Regulated Revenue. At a minimum, the reduction should assure a savings to the public after taking into consideration the payment amounts for the same services in an unregulated setting.

2. The HSCRC or Hospital may initiate a reduction in the Hospital's Approved Regulated Revenue for changes in service levels or due to market share changes as further described in IV. A.

3. The Hospital may initiate a request for an increase in Approved Regulated Revenue for changes in service levels due to market share changes as further described in IV. A. Hospital's request shall be evaluated by the HSCRC staff on a case-by-case basis. The decision of staff represents the final decision.

4. HSCRC makes certain adjustments to all hospitals' rates for certain assessments.[3] These assessments will apply to the TPR hospital in the same manner as applied to other hospitals.

5. HSCRC staff will work with the Hospital to calculate and evaluate any Affordable Care Act ("ACA") induced volume increases in 2014 and 2015 that can be demonstrated for insured populations under the age of 65, net of reductions in volumes for uninsured populations. Based on the findings of this evaluation, HSCRC staff may provide a one-time adjustment to the Hospital's Approved Regulated Revenue.[4]

6. The HSCRC will consider one-time adjustments to hospital regulated revenue for epidemics that result in material increases in utilization or other unanticipated changes beyond the control of the hospital that result in a material increase in utilization.

**E. Exemption from ROC Scaling**

[2] For SFY 2014 through 2016, the Hospital will be subject to the **Readmission Policy Adjustment.** Also, it is possible that HSCRC will develop other shared savings policies that may apply to TPR hospitals, and these policies will need to be incorporated into the annual update process. The implementation of these policies will be subject to negotiation between the Hospital and HSCRC in the context of the overall TPR Agreement.

[3] Health Care Coverage Fund, MHIP, Deficit Assessment, HSCRC and MHCC user fees, NSP, and CRISP are examples of such assessments currently in place and are subject to change by the Commission.

[4] Several recent studies from Massachusetts have estimated minimal volume differences except for black and Hispanic populations of uninsured patients. However, HSCRC recognizes that the impact is unknown and that it is the intent of the HSCRC to provide a timely revenue adjustment for the impact of volume increases arising from the expansion of access to insurance. The HSCRC does not intend to require hospitals to absorb ACA induced volume increases without a revenue adjustment. HSCRC staff will develop a methodology to identify such volume increase and Hospital will have the opportunity to submit supporting information and request an adjustment to its TPR Revenue Base.

If the Hospital operates successfully under this TPR constraint, the Hospital's ROC position may be expected to erode as the Hospital reduces the number of unnecessary inpatient cases and, instead, cares for these patients on a more coordinated way through improved communication and more effective use of ambulatory services. Because this TPR Agreement substantially alters the measurements upon which hospitals are compared for relative efficiency within the State (the HSCRC's ROC), the Hospital will be exempt from negative scaling on the ROC.

The Hospital agrees that it will be subject to adjustments to its TPR Approved Regulated Revenue on a prospective basis for the relative efficiency of the Hospital, provided the HSCRC approves a replacement methodology to its current case-based system for evaluating the hospital's efficiency and that this replacement is appropriate for application to TPR hospitals considering the population-based nature of the approach and considering the investments in interventions required by the Hospital.

## IV. TPR Evaluation, Monitoring, Modification and Cancelation Provisions

### A. Necessary Monitoring of TPR Operation and Performance

Significant increases or decreases in the Hospital's Market Share of patients (receiving regulated hospital services) in its **Primary and Secondary Service Areas** can have materially positive or negative impacts on the efficacy of this Agreement (the Hospital's Primary and Secondary Service Areas are listed by ZIP code and presented in Appendix A to this Agreement). The HSCRC and the Hospital will monitor the Hospital's market share over time by analyzing and identifying any shifts in the Hospital's patient volume from its base year Primary and Secondary service areas. HSCRC and the Hospital will also monitor the total level of services and revenues outside of the Primary and Secondary service levels. Significant changes in the Hospital's market share may be the basis for a renegotiation of the Hospital's TPR constraint as described in subsection D below.

Similarly, significant changes in the care delivery system in the Hospital's Primary and Secondary Service Areas can also positively or negatively influence the appropriateness of the Hospital's current TPR constraint. The Hospital agrees to declare and describe any financial interest (or ownership) it has in non-hospital services provided within the Hospital's Primary and Secondary Service Areas, as of the effective date of this Agreement, in Appendix E. The Hospital must also inform the HSCRC in writing of any significant future acquisitions or divestitures of non-hospital health services.[5] The HSCRC may request data on the utilization of these services historically and over time to ensure that the Hospital achieves compliance with the TPR constraint by better utilization management of existing regulated services and not through a shifting of services from the regulated to the unregulated sectors.

Hospital further agrees to notify the HSCRC staff in advance in writing of any other significant changes to the care delivery system in its primary and secondary service areas as a result of changes initiated by the Hospital, its affiliated providers, or by other care groups not related to the Hospital within 30 days of becoming aware of said developments. The Hospital also agrees to provide an annual disclosure and certification regarding changes in services provided due upon signing of this agreement and on June 30 of each subsequent year. See Appendix D.

[5] This would include the purchase or divestiture of physician practices, joint-venture arrangements with other providers to establish unregulated services that duplicate or could substitute for regulated services currently provided by the Hospital (such as, but not limited to, unregulated clinic, urgent care, or ambulatory surgery services), or other non-hospital services.

HSCRC Staff will also monitor the Hospital's performance on the HSCRC's quality of care metrics (e.g., the Hospital's overall ranking and year-to-year changes in Quality-Based Reimbursement, Maryland Hospital Acquired Conditions, Rates of Preventable Readmissions, review of the Hospital's risk-adjusted Mortality, AHRQ's Prevention Quality Indicators.) The HSCRC expects that the Hospital will, at a minimum, maintain its relative performance ranking on the HSCRC Quality-Based Reimbursement and Maryland Hospital Acquired Conditions rankings during the course of this three year agreement and will improve its rankings relative to Rates of Preventable Readmissions and Prevention Quality Indicators. Should the Hospital fail to maintain its ranking or improve its performance under these quality measures as identified by the HSCRC staff, the HSCRC will notify Hospital of its performance deficiencies. The Hospital will have the opportunity to submit a corrective action plan. Hospital's continued failure to remediate its deficiencies in a reasonable time frame may constitute a cause for termination of this agreement at the discretion of the HSCRC staff.

**B. Evaluation of the Effectiveness of the TPR**

As described above, the primary goal of the TPR is to provide a hospital with strong incentives to treat its community of patients in the most efficient and clinically effective way, resulting in an improvement in the value of care provided. The HSCRC staff agrees to work with the Hospital to develop a scorecard in order to monitor Hospital's effectiveness under the TPR system.

The HSCRC staff may perform an evaluation of the success of the TPR program and report back to the Commission. Success will be evaluated in the context of how well the program contributed to the goal of improving the overall value of care provided at the Hospital (lower cost and better clinical effectiveness/quality). HSCRC staff will pay particular attention to an analysis of utilization trends pre- and post-TPR implementation and an evaluation of per capita hospital and total cost of care in the Hospital's Service Area. This evaluation will also summarize the performance of the Hospital on the Commission's quality of care metrics, and any additional quality of care measurement standards developed by the HSCRC in future years. HSCRC and Hospital agree to specifically review all components of the TPR contract and methodology at the first year anniversary of this contract renewal to mutually determine any TPR methodology changes that may be required.

**C. Possible Modifications to Allow for Better Alignment of Incentives**

Under healthcare reform, a number of approaches are being considered to contain healthcare costs. For example, bundling services under a single payment has been identified prominently as one method for aligning incentives for the efficient delivery of healthcare services. Because healthcare reform efforts are progressing rapidly, the parties to this TPR Agreement may mutually agree to modify its terms to expand the services included within the methodology as these changes are permitted by law and/or regulation. Future changes may include the potential for gain-sharing with physicians and the possible extension of the TPR to cover non-hospital services.

The HSCRC is currently working with the Secretary of the Maryland Department of Health and Mental Hygiene and officials at the Centers for Medicare and Medicaid Services on a revised Medicare waiver

test. As plans for the reformulation of performance measures emerge, HSCRC and the Hospital may agree to alternative savings models, including possible changes to the population and demographic adjustment.[6]

**D. Provisions Governing Other Potential Modifications**

Any request to initiate a reevaluation of the Approved Regulated Revenue constraint by the Hospital shall be submitted in writing to HSCRC staff accompanied by supporting documentation. Similarly, the HSCRC has the right to open discussions with the Hospital, regarding modifications to the TPR constraint based on its on-going review and monitoring of the Hospital's operation and service area market share. A decision to modify the Hospital's Approved Regulated Revenue is within the sound discretion of HSCRC staff, but with the caveat that the Hospital may terminate its participation in the TPR if it is unwilling to accept such a modification.

If the Hospital applies and receives approval to provide a new service to its population area, the Hospital may petition the HSCRC staff for an adjustment to the Hospital's Approved Regulated Revenue if it can be demonstrated to the satisfaction of HSCRC Staff that provision of the new service cannot be managed within its existing revenue constraints. Such requests shall be evaluated by HSCRC staff on a case-by-case basis. Likewise, modifications to the TPR constraint can be initiated by HSCRC staff given other significant changes in the scope of regulated services provided by the Hospital. Decisions of staff on these matters represent a final decision.

As described above, the HSCRC staff and the Hospital will monitor the Hospital's market share of its Primary and Secondary Service Areas over time, as well as the overall volume and revenue for services outside of the Primary and Secondary Service Areas.[7] If either party believes that change in market share and/or utilization is sufficient to justify reevaluation of the revenue cap, that party has the right to initiate such a reevaluation and potential modification to the hospitals TPR constraint.

**E. Cancellation/Renegotiation**

The Commission reserves the right to cancel this Agreement, with cause, at any time. For the purposes of this Agreement, "with cause" includes, but is not limited to, failure by the hospital to provide quality needed services as contemplated by this Agreement as well as the shifting of hospital services to unregulated settings without complying with Commission regulations and policies. In addition, if the Hospital's total all payer or Medicare per capita expenditure trend is greater than the observed rate of increase in the per capita statewide expenditure, the HSCRC will conduct an evaluation. Based on this

[6] Under this three year contract extension, it is recognized by the HSCRC and the Hospital that this TPR agreement is expected to produce savings that accrue to the benefit of the public by applying a revenue constraint that does not provide for volume growth trend except for the population and demographic adjustment defined in Appendix B, thereby producing a total cost trend that is expected to be lower than the trend experienced by other Maryland hospitals under the CPC. See attachment G Executive Summary of the TPR Program which describes the incentives, methodology, and shared savings of the program.

[7] HSCRC staff acknowledges that market share calculations are made difficult by the incentives of this agreement, the movement of cases from one-day-stay to observation, and other factors. If the Hospital operates successfully under this TPR Agreement, it will decrease the level of marginal or unnecessary services provided to the residents of the Hospital's Service Area, and that these service reductions may decrease its share of hospital care to its Service Area residents. It is also acknowledged that it is not the intent of this TPR Agreement to provide the Hospital with a financial incentive to discontinue or to reduce its services. Nevertheless, the HSCRC and the Hospital will work together to identify and evaluate shifts and make adjustments as necessary.

evaluation, HSCRC will retain the right to demand reasonable corrective action. Should the Hospital fail to take this corrective action, the Commission may move to terminate the Agreement allowing for a reasonable period of time for the Hospital to transition out of this Agreement. In the event this Agreement is cancelled, the Hospital will transition to a mutually agreed upon rate system methodology.

## V. Definition of Terms

**Annual Update Factor:** The base update factor as approved by the Commission to apply to all acute care hospitals in the State during the fiscal year, or a portion of the fiscal year.

**Approved Regulated Revenue:** For each Rate Year, the Hospital's approved revenue computed in accordance with this Agreement and specified in the Hospital's Order Nisi for the particular Rate Year. For the Base Year, the Hospital's Approved Regulated Revenue is the approved revenue calculated under the previous TPR arrangement.

**Approved Regulated Revenue Compliance and Related Adjustments:** For each Rate Year, the Hospital's Approved Regulated Revenue will be compared to the Hospital's actual regulated revenue for the particular Rate Year. If the Approved Regulated Revenue exceeds the Hospital's actual regulated revenue, the amount of the excess will be added to the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment.

If the Approved Regulated Revenue is less than the Hospital's actual regulated revenue, the amount of the shortfall will be subtracted from the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment, except that undercharges below the corridor specified in subparagraph III. A will not be so included.

**Base Period:** The SFY 2013 ending June 30, 2013

**Base Period Approved Regulated Revenue:** The total approved revenue of the Hospital for the Base Period (SFY 2013) calculated in accordance with the Hospital's TPR Agreement in effect for the Base Period.

**Demographic Adjustment:** The Demographic Adjustment is the calculation described in Appendix B and the adjustment factors shown therein that provide an adjustment to the Approved Regulated Revenue for population and age related volume changes.

**Maryland Hospital Acquired Conditions Initiative:** The HSCRC's Maryland Hospital Acquired Condition ("MHAC") measurement methodology that compares a hospital's risk-adjusted actual rate of MHAC to an expected or predicted rate of MHAC based on state-wide experience.

**One Time Adjustments:** The HSCRC makes one-time adjustments to the Hospital's rates in deriving the Hospital's Approved Regulated Revenue for the particular Rate Year The HSCRC removes the One Time Adjustments from the Approved Regulated Revenue in calculating Approved Regulated Revenue for a the subsequent Rate Year.

**Primary and Secondary Service Areas** represent the zip codes from which 75% of admissions are derived in the base period. Hospital may petition to remove zip codes to establish zip code dominance.

**Quality-Based Reimbursement:** The HSCRC's pay-for-performance initiative that links hospital performance (both relative and year-to-year) on a list of processes of care measures.

**Rate Years:** The Hospital's Rate Year corresponds to the State fiscal year. For the period of this agreement, the Rate Years are SFY 2014, 2015, and 2016.

**Readmission Policy Adjustment:** In each Rate Year the derivation of the Hospital's Approved Regulated Revenue will include a Readmission Policy Adjustment calculated in accordance with HSCRC policies

**Reasonableness of Charges ("ROC"):** A scaling methodology designed to measure relative cost per case across hospitals and to provide a reduction for hospitals that perform below a certain threshold. Under this agreement, the HSCRC exempts the Hospital from negative ROC scaling.

**Service Area:** The Service Area of the Hospital is a collection of Maryland zip codes and counties as agreed to by the Hospital and HSCRC. Appendix A lists the Maryland zip codes and counties that make up the Hospital's Service Area.

**Unit Rates:** The Approved Regulated Revenue per unit computed for each regulated revenue center in accordance with this Agreement as specified in the Hospital's Order Nisi for the particular Rate Year.

**Unit Rate Compliance:** The Hospital's compliance with its approved Unit Rate in each regulated revenue calculated pursuant to the HSCRC's Unit Rate compliance regulations; however, with relaxed corridors as described in this agreement.

In Witness whereof, the Parties have executed this Agreement and have this date caused their respective signatures to be affixed hereto:

Attest: _____ by _____ Date 11/6/14

Chief Executive Officer
Hospital

Attest: _____ by _____ Date 11/10/14

Executive Director
Health Services Cost Review Commission

**Appendix A – Hospital's Service Area (Zip Codes and Counties)**

The HSCRC will use zip codes for market analysis while using counties for demographic adjustment factors.

The Hospital's Primary and Secondary Service areas are outlined below by zip code:

| PSA | SSA |
|---|---|
| 21613 | 21631 |
| 21643 | 21601 |
| | 21632 |
| | 21664 |
| | 21869 |
| | 21629 |
| | 21634 |

## Appendix B – The Demographic Adjustment

### A. Description

The HSCRC will apply the Demographic Adjustment in each of the three Rate Years of this Agreement when deriving the Hospital's Approved Regulated Revenue for the particular Rate Year. The Demographic Adjustment is one of the Annual Adjustments of this Agreement and is intended to adjust the Hospital's Approved Regulated Revenue for projected changes in the population and the age distribution of the residents of the Hospital's Service Area occurring in the particular Rate Year.

### B. The Demographic Adjustment

The Hospital and the HSCRC have agreed that the Demographic Adjustments for each of the three years of this Agreement will be applied as follows:

| | |
|---|---|
| Calvert Memorial Hospital | 0.52%/year |
| Carroll Hospital Center | 0.51%/year |
| Chester River Hospital Center | 0.47%/year |
| Garrett County Memorial Hospital | 0.27%/year |
| Edward McCready Memorial Hospital | 0.24%/year |
| Meritus Medical Center | 0.38%/year |
| Shore Hospitals (Easton and Dorchester) | 0.41%/year |
| Union Hospital of Cecil County | 0.59%/year |
| Western Maryland Hospital Center | 0.15%/year |

### C. Methodology

HSCRC staff calculated the above demographic adjustment by applying the following methodology:

- Age-based weight cohorts: HSCRC staff stratified statewide inpatient and outpatient total charges from FY 2012 case mix dataset into six age cohorts. Based on statewide Maryland resident estimates provided by the Maryland Department of Planning, HSCRC staff calcuated an associated weight that measures the relative level of hospital services used by residents of Maryland who are included in the particular age cohort. These age cohorts and weights are shown below.

The Demographic Adjustment
Age Cohorts and Weights

| Age Cohort | Weight |
|---|---|
| 0 – 14 | .3338 |
| 15 – 54 | .7216 |
| 55 – 64 | 1.4882 |
| 65 – 74 | 2.3941 |
| 75 – 84 | 3.1840 |
| 85+ | 3.3571 |

- HSCRC obtained from the Maryland Department of Planning the projected population of the Hospital's Service Area for each of the six age cohorts. Using the weights above, HSCRC staff multiplied the projected population in each age cohort by the weight of the particular age cohort and summed the results over the six age cohorts. The Maryland Department of Planning provided the projections in 5 year increments. HSCRC used $2/5^{ths}$ of the first increment (for SFY 2014 and SFY 2015) and $1/5^{th}$ of the second increment (for SFY 2016) to create a 3 year average. The result of this calculation was converted to an annual increment after adjusting for compounding to arrive at an Average Annual Weighted Population Adjustment.

- The HSCRC staff will provide the Hospital 25 percent of the Average Annual Weighted Population Adjustment as the allowed Demographic Adjustment to be applied for each year of this Agreement. Section B, above, lists the Demographic Adjustment by hospital.

- See Attachment 1 for calculations.

**D. Adjustments to the Weights Related to ACA Induced Volume Increases**

The Hospital and HSCRC will work together to decide if a weight adjustment is warranted based on the impact of ACA-induced volume increases in coordination with other ACA-related adjustments addressed in Section III. D of this agreement.

**Appendix C – Readmission Policy Adjustment**

SEE ATTACHED RESULTS OF THE SHARED SAVINGS OFFSET BY HOSPITAL DERIVED FROM THE JUNE 11, 2014 HSCRC APPROVED SHARED SAVINGS POLICY

**Appendix D – Annual Disclosure and Certification Regarding Changes in Services Provided Due June 30 of each year**

____The following services were shifted in whole or in part to unregulated settings:

____The following services were shifted in whole or in part to other hospitals:

Or

__✓__The Hospital is not aware of any services that were shifted in whole or in part to unregulated settings.

__✓__The Hospital is not aware of any services that were shifted in whole or part to other hospitals.

[signature] _____ 6/6/14 _____

Signature of Officer Date

**Appendix E - Hospital Financial Interest (or Ownership) in Non-Hospital Services Provided Within the Service Area**

Shore Medical Center – Dorchester owns, has a substantial financial interest in, controls, or is financially or organizationally related to the following provider organizations or systems.

1. Care Health Services, Inc.
2. Shore Clinical Foundation, Inc.
3. Chester River Manor, Inc.
4. Chester River Home Care & Hospice, LLC
5. Memorial Hospital Foundation, Inc. & Subsidiary
6. Innovative Health Services, LLC (50% ownership)
7. University of Maryland Shore Regional Health, Inc.
8. Eastern Shore Endoscopy, LLC (10% ownership)
9. Dorchester General Hospital Foundation, Inc.
10. Chester River Health Foundation, Inc.

**Appendix F -- Calculation of Market Share**

While the following calculation is not binding, it is suggested as a calculation to examine possible changes in market share given the complexities arising from evaluating shifts in market share under the incentives of population based payment models.

**Volume of Services**: In considering whether adjustments to the Hospital's Approved Regulated Revenue are warranted for shifts in market share, the changes in the service levels of the Hospital and for the relative service levels of other service area hospitals will need to be calculated for selected services These service levels will be calculated for the Base Year and for each Rate Year.
The measure of the volume of service will be calculated for the Hospital and for each other applicable hospital separately for inpatient and outpatient services

The outpatient services will be converted to an inpatient equivalent volume of services.

For each hospital, including the TPR Hospital, which provides services in the particular category, the hospital's Volume of Service will be calculated as follows:

(1) The Inpatient volume of services will equal the number of case mix adjusted discharges (CMADs) of the hospital's inpatients whose services are included in the particular category, , and

(2) The Outpatient Volume of Service

   a. The hospital's Unit Charge will be calculated as the average charge per CMAD over all of the hospital's inpatients, excluding outliers.

   b. The outpatient equivalent CMADs (ECMADs) will be calculated as the hospitals total charges, exclusive of charges of inpatients included in the count of CMADs, divided by the Unit Charge.

(3) The hospital's volume of service for the particular category of services will equal the sum of the number of CMADs calculated in step (1) and the number of ECMADs calculated in step (2).

The total volume of service of a particular category of services in which the services are provided by several hospitals will equal the sum of each hospital's volume of service as calculated above.

HSCRC will continue to work with the hospital on the methods for calculating service level and market share changes, recognizing that this is a work in progress, and each party will continue to focus on improving the methods to evaluate changes in market share separate from other changes in efficiency levels.

## Appendix G- Executive Summary of the TPR Program