maryland
health services
cost review commission

Payment Model Workgroup

May 30, 2024

STAKEHOLDERS' COMMENTS

Comment Letters Received

Letters were received from:

- Maryland Hospital Association (MHA)
- University of Maryland Medical Systems
- LifeBridge Health
- Tidal Health
- Ascension Saint Agnes
- Sheppard Pratt
- Mount Washington Pediatrics
- Atlantic General
- MedStar Health
- CareFirst
- Adventist Healthcare
- Holy Cross Health
- Johns Hopkins Health System*

Comments generally focused on 7 areas:

1. Fund Current Inflation
2. Catch Up Methodology
3. Revised PAU Policy
4. Clarification of Set-Aside
5. Outpatient Oncology & Infusion Drugs
6. Retained Revenue
7. Support Inflation for Specialty Hospitals

* comment letter not submitted on time

Draft Recommendation

The draft recommendation reflected inflation from Global Insight's 4th Quarter 2023 book and additional inflation support based on five years of cumulative underfunding using 2019 as a base.

Draft Recommendation Inflation Breakdown	
Adjustment for Inflation (4th Quarter Book)	**3.05%**
Additional Inflation Support	**0.65%**
Outpatient Oncology Drugs	**0.10%**
Gross Inflation Allowance	**3.80%**
PAU Shared Savings	**0%**

1. RY2025 Update Factor Comments: Fund Current Inflation

- All Hospitals requested that the Commission fund current inflation to 3.24%, reflecting data from Global Insight's First Quarter 2024 book.

HSCRC Staff Response: Staff agree to update current inflation to Global Insight's First Quarter 2024 book to reflect 3.24%. This new value will be reflected in the Final Recommendation. The update will have an effect on TCOC savings and the magnitude of any catch up inflation value.

Draft Recommendation: Inflation Catch Up Methodology

- Staff believe a review of underfunded inflation is warranted, but any adjustments for underfunding of inflation should have the following guiding principles:
  - Consider historical overfunding allowances
  - Allow for two-sided risk
  - Utilize multi-year solutions to ensure savings tests are met
  - Establish formulaic methods that are predictable to hospitals and payers
- Staff's proposed methodology takes these guiding principles into account:
  - Establishes the cumulative overfunding value that the Commission allowed without revising future funded inflation downwards (1.18%), i.e., the two-sided risk corridor or max tolerance.
  - Evaluates current 5 year over/underfunding through 2023 (2.16%)
  - Reconciles current over/underfunding to two-sided risk corridor
  - Yields additional inflation of 0.98%

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%
(Under)/Over Funding	(0.10%)	0.56%	0.74%	(0.37%)	0.20%	(0.08%)	0.65%	0.40%	(2.22%)	(1.03%)
5 Year Cumulative Difference	(0.10%)	0.45%	1.18%	0.82%	1.01%	1.03%	1.12%	0.78%	(1.00%)	**(2.16%)**
Max Tolerance **(A)**	1.18%				Absolute of 5 Year Cumulative 2018-2023 **(B)**			2.16%		
Max Funding Solution **C = B-A**					**0.98%**					

- All additional inflation values still need to be considered against required savings

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2. RY2025 Update Factor Comments: Inflation Catch-Up Methodology

- CareFirst suggests that there should be no additional funding provided in RY 2025 because the catch up methodology doesn't account for prior overfunding
  - Hospitals have been "cumulatively overfunded by more than $1 billion above actual inflation"
- If any catch up inflation is provided in RY 2025, CareFirst suggests targeting additional funding to invest in reducing statewide maternal mortality rate by 50% over 5 years. In addition, CareFirst suggests providing 0.1% funding in rates paid via an assessment to MHA to create a Maternal Quality Care Collaborative.
  - If improvements are not made over 5 years, the additional funding provided for this effort should be removed from rates.

HSCRC Staff Response: HSCRC staff agree that the catch up methodology should account for prior overfunding and thus are amending the staff recommendation to utilize a 2014 baseline. Staff, however, do not agree with CareFirst's assessment of cumulative overfunding, as it takes into account cash reserves and fails the typical regulatory standard of making adjustments in a prospective manner. Moreover, this same approach was not taken into account when resolving the census forecasting error in the Demographic Adjustment, which would have showed significant, negative impacts to cash reserves.

Lastly, while staff appreciate CareFirst's novel proposal to address maternal mortality, this type of policy action, which is unrelated to the adequacy of inflation, should be vetted with a technical workgroup and other key stakeholders, most notably the Department of Health.

2. RY2025 Update Factor Comments: Inflation Catch-Up Methodology

- All Hospitals are in support of a catch-up methodology to address the underfunding of inflation that has occurred in RY 2022 and RY 2023. MHA and it's member hospitals request that half of the 2.34% totaling 1.17% be funded in RY 2025 and the remainder be funded in RY 2026. The 2.34% is based on a 5 year cumulative growth calculation which considers RY 2020- RY2024. In addition, any correction for overfunded inflation be limited to 0.5% per year and not be applied if savings exceed the Medicare target. If adjustments exceed 0.5%, they should be spread over multiple years to ensure financial stability and predictability.
  - Request for additional funding to address underfunded inflation in FY25. They propose targeting this funding to efficient hospitals and scaling a portion to limit growth for "Low-Efficiency Outliers". *(Tidal Health)*

HSCRC Staff Response: HSCRC staff believe there needs to be a catch up methodology that can be used moving forward, but disagree on the approach proposed by the MHA and it's member hospitals.

a) *Calculation of over/(under)funding should go back to 2014 and calculate cumulative funding through 2023. Staff do not agree that 2024 should be included in the calculation of funding since that period is not considered 'final'.*
b) *There must be two-sided risk and overfunding should have the same corridor as underfunding. The impact to consumers, as well as hospitals, must be considered in this methodology.*
c) *Any catch up inflation will be applied to all hospitals equitably.*
d) *Additional inflation values still need to be considered against required savings.*

2. Updated Inflation Methodology

Inflation Catch-Up Methodology

Max Tolerance =	**1.00%**					**1.00%**							
HSCRC Scenario/Table 1 - Inflation Resolved after First Policy Year	**Historical**										**Projected**		
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
HSCRC Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%	3.15%	3.24%	3.24%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.15%	3.24%	3.24%
Actual Inflation Correction												1.00%	0.00%
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	0.00%	1.00%	0.00%
Cumulative Difference (2019 Base)						(0.08%)	0.56%	0.95%	(1.19%)	(2.16%)	(2.16%)	-1.18%	-1.18%
Cumulative Difference (2014 Base)	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(1.17%)	-0.18%	-0.18%
Guardrail/Tolerance **(A)**										1.00%	1.00%	1.00%	1.00%
Cumulative Difference with Anticipated Inflation Correction (2014 Base) **(B)**	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(0.18%)	(0.18%)	(0.18%)
Calculated Inflation Correction (C) = (A+1)/(B+1)-1)									**1% for stub period**	1.00%	0.00%	0.00%	0.00%
Inflation Adjusted Update											3.15%	4.24%	3.24%

Changes to Catch Up Inflation Methodology:

- 2014 baseline (1.17% underfunding) in lieu of 2019 baseline (2.16% underfunding)
- 1% funding to be provided in RY 2025
- Risk corridor changed from 1.18% to 1% for future evaluations

Draft Recommendation: PAU

Staff proposed to continue utilizing the PAU Shared Savings program in order to recognize differential opportunities in a fixed revenue model; however, Staff are recommended that the PAU Shared Savings program should not be used to generate Model savings, as the policy has already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and future reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions.

- (0.37%) PAU Reduction, 0.00% Statewide Impact

Staff also recommended the following:

1) An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU; 2) Establishment of a single point of executive accountability for the PAU reduction strategy; and 3)Agreement to engage in future analyses of PAU performance.

3. RY2025 Update Factor Comments: PAU

- Various Commissioners expressed concern that under the new methodology, select hospitals will receive a reward, i.e., a net increase to their revenue base, and it is unclear if the hospitals have done anything to warrant such a reward
- Almost all hospitals are in support of adjusting the PAU savings methodology to better reflect hospitals' ability to influence their rates while funding full inflation. They also support maintaining incentives for care transformation and seek clarification on certain aspects of the staff recommendation.
    - Medstar agrees with Staff's draft recommendation that an analysis to be funded out of hospital rates and activities of current interventions to reduce PAU, an establishment of a single point of executive accountability for the PAU reduction strategy, and an agreement to engage in future PAU performance analyses. They further emphasize the need for additional analyses to acknowledge that not all PAU volume is avoidable.

HSCRC Staff Response: Staff ran several analyses to see if there was a relationship between the rewards in the new PAU methodology and improvement in PAU performance over the course of the Model. While there were occurrences where hospitals have clearly demonstrated improvement and are in a position to get a reward (e.g., Garrett Regional Medical Center, MedStar St. Mary's, Chestertown Hospital), there was not a statistically significant relationship across the entire industry. Similarly, hospitals attainment performance at the start of the Model was not correlated with the current reward structure, suggesting that the proposed methodology captures both hospitals that had excellent performance at the start of the Model but have not necessarily decreased PAU (e.g., Holy Cross) and hospitals that have improved under the Model. In light of this finding, staff recommend amending the PAU Shared Savings policy to cap rewards for hospitals to 0%. In addition to a single point of accountability, hospitals would need to submit a plan for Commission approval to reduce PAU or maintain low rates of PAU.

Staff appreciates the hospital support to amend the PAU policy and to review PAU performance over the course of the Model. If approved by the Commission, staff will utilize a portion of the set aside ($500k-$1M) to contract a vendor to be in charge of PAU performance before the start of next calendar year.

4. RY2025 Update Factor Comments: Set Aside Funding

- Several hospitals express concerns about the estimate of set-aside funding, emphasizing the need for transparency and clear criteria for distribution.
  - Support the commission's proposal but stress the importance of developing fair criteria for accessing these funds *(UMMS & LifeBridge)*
    - One hospital specifically cited concerns over using cash-on-hand to determine financial hardship, stating it can be misleading when establishing need. *(LifeBridge)*
  - Suggestion to prioritize funding for "High-Efficiency Outliers" before other requests. *(Tidal Health)*
  - Opposed increasing set aside funding, citing concerns about creating incentives and impacting inflation funding for all hospitals. *(MedStar)*

HSCRC Staff Response: Given the relatively strong support to establish criteria for distributing set aside funding, and yet no proposals for what the criteria should be (other than removal of a cash consideration), staff are putting forward the proposal from the draft recommendation with one amendment. Staff also share MedStar's concerns that increasing the set aside could crowd out potential inflation for all hospitals and could increase the likelihood of a woodwork effect, i.e., hospitals request funding purely because there is available revenue. For these reasons, staff do not believe that the funding for the set aside should be larger and again notes the need for sufficient gatekeeper tests to access funding for financial hardship, similar to what is utilized in the Integrated Efficiency policy.

1) *The below criteria must be met to provide funding to hospitals with a clear financial hardship:*
   - *Below State Average Margin*
   - *Regulated Margin decline of more than 3%*
   - *Total Operating Margin decline of more than 1%*
   - *125 days cash on hand or two consecutive years of negative Cash Flow from Operations (on the regulated entity)*
2) *The Commission will create a process where the set aside is distributed through a competitive process*
   - *Twice per year (depending on funding availability) hospitals submit applications citing either relative efficiency performance or financial hardship and the details of their revenue request*
   - *Staff provide recommendations in subsequent meeting*
   - *Commissioners vote on requests*
   - *Hospital must submit a corrective action plan approved by their Board*

Draft Recommendation: Outpatient Oncology and Infusion Drugs

- Staff have previously evaluated providing hospital specific inflation, historically, all hospitals have received an equal drug inflation because analysis has shown the experienced inflation was relatively consistent across hospitals.

- The inflation beginning in 2022 appears to be concentrated in the more specialized drugs that are primarily delivered by academic institutions. Therefore, staff is recognizing this new round of inflation by recommending a small increase from 0 percent to 2.5 percent for all hospitals but a larger increase for just the academic centers of 7.5 percent. The 5 percent point gap reflects the observed gap between academic and non-academic trends in 2022 and 2023.

5. RY2025 Update Factor Comments: Outpatient Oncology and Infusion Drugs

- Hospitals have seen a significant rise in pharmaceutical costs that exceed core inflation. There is concern about the differing treatment for Academic Medical Centers. Hospitals are requesting that there should be no distinction in inflation rates and that any substantial changes in inflation or cost increases should be thoroughly evaluated before being implemented long-term. The impact of this funding on non-academic hospital rates means that fewer hospitals are able to provide care in to the community. Hospitals suggest that high-cost drug cases should be funded outside of the GBR and operated on a fee-for-service basis.

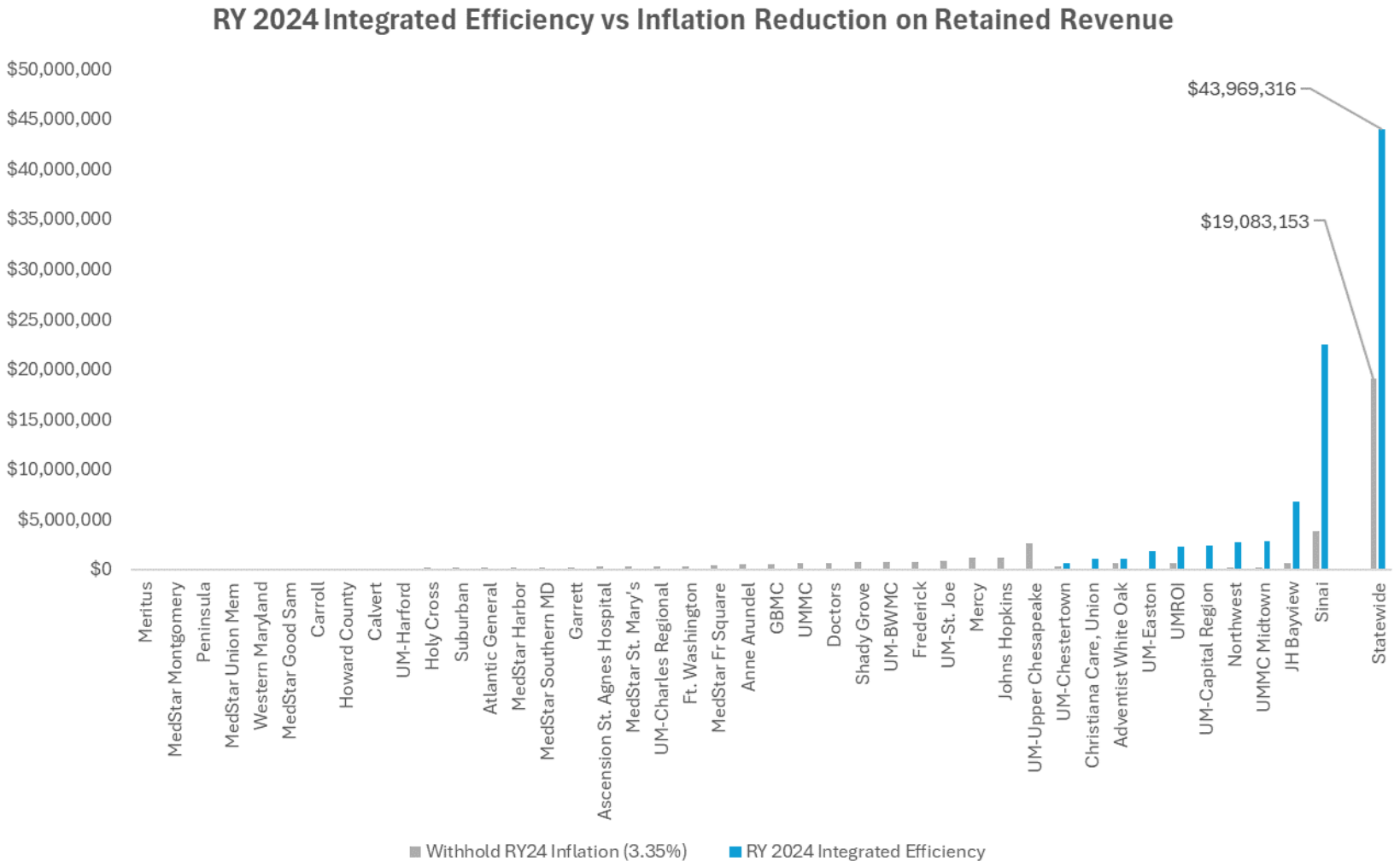
HSCRC Staff Response: The distinction in inflation rates between Academic Medical Centers and other hospitals was based on a thorough evaluation of the data. Academic medical centers have experienced higher cost growth over recent years and the proposed differential inflation rates reflects that. It is also consistent with the guidelines established in prior years when Staff noted that differential inflation rates could be used if trends diverged between hospitals. Prior to this year the data has not indicated for this adjustment. Staff agrees that a review of the policies related to high cost drug would be appropriate and plans to initiate a review during FY 2025.

6. RY2025 Update Factor Comments: Retained Revenue

- During the presentation of the Draft Recommendation of the Update Factor, Commissioners raised concerns regarding the funding of inflation on retained revenue. It was suggested that inflation should only be funded on the portion of revenue not related to retained revenue or scaled to accommodate retained revenue at the hospital.

HSCRC Staff Response: Staff disagree with this idea. The GBR rewards hospitals by allowing them to retain revenue as volumes decline (at 50% VCF). This incentive is fundamental to the Model to ensure that there is funding available in hospitals to invest in population health, physicians and other opportunities that will improve total cost of care in their service areas. The side effect of too much retained revenue, is that a hospital may operate inefficiently, which is why the Integrated Efficiency Policy was created and approved by the Commission in April of 2021. This policy is the mechanism by which retained revenue should be addressed and have that revenue removed from the system. Removing retained revenue from all hospitals rather than just outliers, as currently outlined in the policy may disincentivize hospitals to manage total cost of care and invest in their service area.

6. To Retain or not to Retain?



Defunding inflation on retained revenue versus implementing Integrated Efficiency has three central flaws:

1. It achieves less in savings and/or opportunity for reinvestment ($19.1M versus $43.9M in RY 2024)
2. It broadly distributes the reduction to most all hospitals, thus reducing the impetus to transform care delivery
3. It upends the central incentive of the Model

"The largest incentives in the MD TCOC Model are the all-payer hospital global budgets. At the start of each year, HSCRC sets a budget across all payers for each hospital in the state. These budgets, which continue from MDAPM, encourage hospitals to reduce avoidable hospital use by improving beneficiaries' health or shifting care to lower-acuity settings"

https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt, page ES-2

1) Retained revenue is calculated on a per case basis, assuming a 50% variable cost factor
2) Retained revenue calculations include revenue adjustments related to marketshift, demographic adjustment, PAU shared savings, out-of-state volume adjustments, deregulation, and other miscellaneous volume adjustments
3) Retained revenue calculations exclude oncology drugs, chronic cases, and cases eligible under the Complexity and Innovation policy

Draft Recommendation: Specialty Hospital Update

Draft Recommendation Inflation Breakdown: Specialty Hospitals	
Inflation	**3.15%**
Productivity Adjustment	**Suspended**
Additional Inflation Support	**0.00%**
Gross Inflation Allowance	**3.15%**

7. RY2025 Update Factor Comments: Non-GBR Hospitals

- Non-GBR hospitals should receive full inflation and an additional adjustment for underfunded inflation in FY 2025, equivalent to GBR hospitals. As downstream providers with low volumes still below CY 2019 levels, they struggle to maintain positive margins and required staffing.

HSCRC Staff Response: HSCRC Staff agree to include the catch up inflation value of 1.00 percent in the Final Recommendation. Volumes remain low compared to 2019 at the specialty hospitals, but demand remains high. Specialty hospitals experience the same inflationary pressures as acute hospitals. The cost pressures, specifically, specialized staffing needs make it difficult for these hospitals to fill vacancies and as a result are these hospitals utilizing agency staffing in higher levels. These hospitals represent an important component of the overall delivery system in Maryland and ensuring continued access to these services is crucial.

8. Population Health Consideration

- Commissioners expressed concerns that reducing the system-wide inflation reduction for PAU would reduce the incentive for hospitals to improve or sustain efforts to reduce PAU.
- CareFirst also indicated that an increased portion of the Update Factor should be directed to population health improvement efforts.
- As such, staff are considering a withhold of 0.19% of the Update Factor (equivalent to half of the proposed modification to the PAU reduction), which would be released to each hospital in the January rate orders once the following conditions are met:
  - A plan, subject to Commission approval, for population health improvement aligned with statewide priorities
  - The withhold will be evaluated in future years if there is not demonstrated improvement in the proposed initiative

Final Recommendation

The final recommendation reflects changes due to Commissioner and stakeholder feedback

Summary of Changes between Draft & Final Recommendations		
GBR Hospitals	**Draft Recommendation**	**Final Recommendation**
Adjustment for Inflation (4th Quarter Book)	3.05%	3.14%
Additional Inflation Support	0.65%	1.00%
Outpatient Oncology Drugs	0.10%	0.10%
Gross Inflation Allowance	3.80%	4.24%
PAU Shared Savings	0.00%	-0.02%
Non-GBR Hospitals		
Inflation	3.15%	3.24%
Productivity Adjustment	Suspended	Suspended
Additional Inflation Support	0.00%	1.00%
Gross Inflation Allowance	3.15%	4.24%

Update Factor Discussion

Balanced Update Model for RY 2025					
Components of Revenue Change Link to Hospital Cost Drivers /Performance					
			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 4.00% for Wages and Salaries)			3.14%	$664.2	$219.2
- Additional Inflation Support			1.00%	$211.6	$69.8
- Outpatient Oncology Drugs			0.10%	$21.4	$7.1
Gross Inflation Allowance	**A**		**4.24%**	**$897.1**	**$296.1**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.21%	-$45.1	-$14.9
- Grant Funding RY25: RP for Behavioral Health & Maternal and Child Health			0.14%	$29.7	$9.8
Total Care Coordination/Population Health	**B**		**-0.07%**	**-$15.4**	**-$5.1**
Adjustment for Volume					
-Demographic /Population			0.25%	$52.9	$17.5
-Drug Population/Utilization			0.00%	$0.0	$0.0
Total Adjustment for Volume	**C**		**0.25%**	**$52.9**	**$17.5**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.15%	$31.7	$10.5
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		-0.01%	-$3.1	-$1.0
-Reversal of one-time adjustments for drugs	G		-0.10%	-$21.9	-$7.2
-Capital Funding & Estimated Increase for Full Rate Applications	H		0.17%	$36.5	$12.0
Net Other Adjustments	**I =**	**Sum of D thru H**	**0.20%**	**$43.2**	**$14.3**
Quality and PAU Savings					
-PAU Redistribution (-.38%)	J		-0.02%	-$5.05	-$1.7
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		0.08%	$17.6	$5.8
-Current Year Quality Incentives	L =		-0.12%	-$25.2	-$8.3
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.06%**	**-$12.7**	**-$4.2**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**N=**	Sum of A + B + C + I + M	**4.56%**	**$965.2**	**$318.5**
Per Capita	**O=**	(1+N)/(1+0.25%)	**4.30%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
-Uncompensated care, net of differential	P		0.14%	$29.6	$9.8
-Deficit Assessment	Q		0.00%	$0.0	$0.0
Net decreases	**R =**	P + Q	**0.14%**	**$29.6**	**$9.8**
Total Update First Half of Rate Year 25					
Revenue growth, net of offsets	**S =**	N + R	**4.70%**	**$994.8**	**$328.3**
Per Capita Revenue Growth	**T =**	(1+S)/(1+0.25%)	**4.44%**		
Adjustments in Second Half of Rate Year					
- Transformation Funding					
Total Adjustments Second Half of Rate Year	**U**		**0.09%**	**$20.0**	**$6.6**
Total Update Full Rate Year					
Revenue growth, net of offsets	**V =**	Q + U	**4.80%**	**$1,014.8**	**$334.9**
Per Capita Revenue Growth	**W =**	(1+V)/(1+0.25%)	**4.53%**		

Estimated Position on Medicare Test		
Actual Revenue January - June 2023		10,280,594,777
Actual Revenue July-December 2023		10,452,399,742
Actual Revenue CY 2023		20,732,994,519
Step 1:		
Approved GBR RY 2024		21,159,064,172
Actual Revenue 7/1/23-12/31/23		10,452,399,742
Approved Revenue 1/1/24-6/30/24		10,706,664,430
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/24-6/30/24	**A**	**10,706,664,430**
Expected Revenue Growth 1/1/24-6/30/24		**4.14%**
Step 2:		
Final Approved GBR RY 2024		21,159,064,172
Reverse All Payer Rate Reduction:		20,000,000
Final Adjusted GBR Base for RY 2025		21,179,064,172
Projected Approved GBR RY 2025		22,174,807,962
Permanent Update RY 2025		4.70%
Step 3:		
Estimated Revenue 7/1/24-12/31/24 (after 49.73% & seasonality)	**B**	**11,027,531,999**
Expected Revenue Growth 7/1/24 - 12/31/24		***5.50%***
Step 4:		
Estimated Revenue CY 2024	**A+B**	**21,734,196,430**
Increase over CY 2024 Revenue		**4.83%**
Per Capita Increase over CY 2024		**4.57%**

CY 24 Guardrail Scenario 1: 2023 Trended forward at 2017 - 2019 Trend

Scenario 1 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,708	$13,006	Predicted Variance
YOY Growth	4.6%	3.8%	0.8%
Estimated CY2024 Savings Run Rate			$404.6 M

CY 24 Guardrail Scenario 2: 2023 Trended forward at 2015 - 2019 Trend

Scenario 2 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,633	$12,875	Predicted Variance
YOY Growth	4.1%	2.8%	1.3%
Estimated CY2024 Savings Run Rate			$339.0M

CY 24 Guardrail Scenario 3: 2023 Trended forward at 2022 - 2023 Trend

Scenario 3 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,888	$13,178	Predicted Variance
YOY Growth	5.9%	5.2%	0.7%
Estimated CY2024 Savings Run Rate			$427.5 M

Final Recommendations

For Global Revenues:

- Provide all hospitals with a base inflation increase of 3.24 percent, with an additional 1.0 percent for additional revenue support based on cumulative underfunding of inflation since 2014.
- Provide an overall increase of 4.80 percent for revenue (including a net increase to uncompensated care) and 4.54 percent per capita for hospitals under Global Budgets, as shown in Table 2.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 3.24 percent for inflation, with an additional 1.0 percent for additional revenue support based on cumulative underfunding of inflation since 2014.
- Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.