maryland
health services
cost review commission

Final Recommendation for the Update Factors for Rate Year 2023

June 8, 2022

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List of Abbreviations

ACA	Affordable Care Act
CAGR	Compounded Annual Growth Rate
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital Acquired Conditions
MPA	Medicare Performance Adjustment
MPA-SC	Medicare Performance Adjustment - Saving Component
OACT	Office of the Actuary
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The final recommendation provides an annual update factor of 3.38 percent per capita, a revenue increase of 3.25 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.66 percent for hospitals not under Global Budgets which includes psych hospitals and Mt. Washington Pediatrics. The updates for GBR hospitals and specialty hospitals include an additional 0.40 percent for inflation catch up.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2023. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement.	The annual update factor contains the growth of costs for all payers and also reflects ongoing investments in population health and health equity through the Regional Partnership programs. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Summary

The following report includes the final recommendation for the Update Factor for Rate Year (RY) 2023. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness, both during and after the COVID-19 response, and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. Staff recognizes that the COVID-19 crisis continues to create significant uncertainty and will likely drive large, short, and long-term changes in the healthcare industry. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis and its lingering effects on healthcare in the State of Maryland. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability and slowing the growth of healthcare costs.

Staff requests that Commissioners consider the following final recommendations:

For Global Revenues:

(a) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs. Furthermore, provide an additional 0.40 percent to account for the underfunding of inflation through the pandemic from FY 2020 - FY 2022.

(b) Provide an overall increase of 3.25 percent for revenue (including a net change to uncompensated care) and 3.38 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

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

(a) Provide an overall update of 3.66 percent for inflation and an additional 0.40 percent to account for the underfunding of inflation through the pandemic for FY 2020-FY2022.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year, the HSCRC is considering the extraordinary circumstances of the COVID-19 response in the development of the update factor. As in all the HSCRC policies, this final recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of $300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality

improvements, and improve the health of the population. It is worth mentioning that Maryland has already met the 5-year total cost of care savings requirement under the Total Cost of Care Agreement, but this progress must be sustained through 2023 as the savings requirement is not a cumulative test.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure after the COVID-19 crisis abates that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to develop the RY 2023 annual update is outlined in this report, as well as staff's estimates on calendar year Model tests.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

This recommendation proposes Rate Year (RY) 2023 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2023, HSCRC staff is proposing an update of 3.38 percent per capita for global budget revenues and an update of 4.06 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's First Quarter 2022 market basket growth estimate with a capital growth estimate. For RY 2023, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth estimate of 2.20 percent, calculating the gross blended amount as a 3.66 percent inflation adjustment.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the inflation adjustment of 3.66 percent. The pandemic's effect on hospitals continues to result in historically low volumes. For this reason, HSCRC staff propose to withhold the productivity adjustment from this year's gross blended inflation amount. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years. After review of inflation over the course of the pandemic from RY 2020 - RY 2022, staff have determined that hospitals have been underfunded by approximately 0.40 percentage points. That amount has been added to the inflation amount outlined in Table 1 below. Table 3 outlines this inflation catch up in more detail.

Table 1

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.66%	3.66%
Inflation Catch-Up	0.40%	0.40%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	4.06%	4.06%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.68 percent and per capita growth of 3.81 percent for RY 2023. After accounting for changes in uncompensated care

and assessments, the HSCRC estimates net revenue growth at 3.25 percent with a corresponding per capita growth of 3.38 percent for RY 2023.

To measure the proposed update against financial tests, which are performed on Calendar Year results, staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2023 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2

Balanced Update Model for RY 2023

Components of Revenue Change Link to Hospital Cost Drivers /Performance

			Weighted Allowance
Adjustment for Inflation (this includes 4.80% for wages and compensation)			3.64%
- Outpatient Oncology Drugs			0.02%
- Inflation Catch Up			0.40%
Gross Inflation Allowance	**A**		**4.06%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.22%
- Regional Partnership Grant Funding RY23			0.20%
Total Care Coordination/Population Health	**B**		**-0.03%**
Adjustment for Volume			
-Demographic /Population			-0.12%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**-0.12%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.10%
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.00%
- Complexity & Innovation	G		0.14%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.20%**
Quality and PAU Savings			
-PAU Savings	J		-0.32%
-Reversal of prior year quality incentives - QBR, MHAC, Readmissions	K		-0.11%
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.43%**
Total Update First Half of Rate Year 23			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**3.68%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1-0.12%)	**3.81%**
Adjustments in Second Half of Rate Year 23			
-Oncology Drug Adjustment	P		0.00%
-Current Year Quality Incentives	Q		TBD
Total Adjustments in Second Half of Rate Year 23	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 23			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.68%**
Per Capita Fiscal Year	**T =**	(1+S)/(1-0.12%)	**3.81%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		-0.43%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**-0.43%**
Total Update First Half of Rate Year 23			
Revenue growth, net of offsets	**X =**	N + W	**3.25%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1-0.12%)	**3.38%**
Total Update Full Rate Year 23			
Revenue growth, net of offsets	**Z =**	S + W	**3.25%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1-0.12%)	**3.38%**

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.66 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth index change of 2.20 percent. The adjustment for inflation includes 3.90 percent for wages and compensation. A portion of the 3.66 inflation allowance (0.02 percent) will be allocated to hospitals to more accurately provide revenues for increases in outpatient oncology and infusion drugs . This drug cost adjustment is further discussed below. After further evaluation of inflation during the course of the pandemic, hospitals have been underfunded for RY 2020-RY2022 by approximately 0.40 percent. The details of this calculation can be reviewed in Table 3 below.

Table 3

	RY 2020	RY 2021	RY 2022	Cumulative Growth
Funded Inflation	2.96%	2.77%	2.57%	8.53%
Actual Inflation	2.31%	2.01%	4.42%	8.98%
	0.65%	0.76%	-1.85%	-0.40%

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

  Starting in Rate Year 2021, staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2023 continues this practice. While volume continues to grow for these drugs, staff analysis shows that the price per drug of the drugs covered has stabilized and

the need for a higher inflation rate on this component of spending has been mitigated. This trend was recognized in Rate Year 2021 through a lowering of the drug inflation factor from 10 percent to 6 percent. Staff reviewed trends from 2018 to 2021 and determined that price and mix trends remain well below prior years. Therefore, staff is proposing a 1 percent drug inflation factor for RY 2023, which calculates to 0.02 percent that will be earmarked for outpatient oncology and infusion drugs.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2022 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, Maternal and Child Health Improvement Fund Assessment, Population Health Workforce Support for Disadvantaged Areas, and transition funding for Regional Partnership Legacy Grants. These funds were provided to hospitals on a one-time basis. For this reason, you will see a line in Table 2 reversing out grant funding in RY 2022 of -0.22 percent. RY 2023 funding is expected to be approximately 0.20 percent and includes continued funding for Diabetes and Behavioral Health, as well as Maternal and Child Health.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2022 is -0.12 percent. For RY 2023 the staff is proposing to use the value of the Department of Planning CY 2022 growth estimate for the Demographic Adjustment in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals. Due to the confounding impact that the COVID-19 pandemic has had on data, staff will not implement an efficiency policy effective July 1, 2022, but is assessing if a mid-year efficiency policy that addresses COVID concerns could be utilized in January 2023.

- **Set-Aside for Unforeseen Adjustments:** Staff recommends 0.10 percent set-aside to use for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits

dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center in RY 2017, 2018, 2019, 2020, and 2021. Based on this analysis, staff concluded that the historical average growth rate was 0.54 percent, which equates to a combined state impact of 0.14 percent for the RY 2023 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2023 PAU savings adjustment, of -0.32 percent, is calculated based on update factor inflation and demographic adjustment applied to CY 2021 PAU performance
- **Quality Scaling Adjustments:** These pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR).

  Over the past several months, staff have worked with the Performance Measurement Workgroup to assess potential modifications to the underlying measurements and methodologies for the RY 2023 pay-for-performance programs due to the confounding effects of the COVID public health emergency. While many workgroup members supported staff's guiding principle to adjust or not adjust for COVID in a uniform fashion across the three core quality programs, other workgroup members remain concerned about the overall deterioration in revenue adjustments relative to RY 2022.

  Staff note that the recently released proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) outlines that various components of the federal value-based purchasing programs will not be included in the federal RY 2023 payment program due to data validity concerns. Specifically, the proposed rule may make the Hospital Value-Based Purchasing (HVBP) program and the Hospital Acquired Conditions Reduction Program (HACRP) revenue neutral for federal RY 2023. These programs are analogous to the QBR and MHAC programs, respectively.

  Given the uncertainty of the federal programs, which are the basis for the required at-risk in programs in Maryland, staff are recommending that Quality programs in the RY 2023 Update Factor remain to be determined and that any adjustments determined through further engagement of the Performance Measurement Workgroup be implemented in January rate orders. Depending on the final IPPS rule, which will not be promulgated until after the start of the State fiscal year, staff may revise its recommendations to align with federal guidance. Similarly, if the final IPPS rule recommends any changes to the Hospital Readmissions Reduction Program (HRRP), which is the analog for RRIP, staff will potentially modify revenue adjustments for this program as well.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2023 will be -0.43 percent. The amount in rates was 4.65 percent in RY 2022, and the proposed amount for RY 2023 is 4.22 percent, a decrease of -0.43 percent.
- **Deficit Assessment:** The legislature did not propose a further reduction to the Deficit Assessment in RY 2023, and as a result, this line item is 0.00 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2023, the incremental amount of statewide PAU Savings reductions is determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This will result in a RY 2023 PAU savings reduction of -0.32 percent statewide, or $60,153,549. Hospital performance on avoidable admissions per capita and 30 day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 4

Statewide PAU Reduction	Formula	Value
RY 2022 Total Estimated Permanent Revenue*	A	$18,797,984,034
RY 2023 Inflation Factor**	B	3.52%
CY 2019 Total Experienced PAU $	C	$1,719,724,282
RY 2023 Proposed Revenue Adjustment $	D = B*C	-$60,534,295
RY 2023 Proposed Revenue Adjustment %	E = D/A	-0.32203%
RY 2023 Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.32%**
RY 2023 Adjusted Proposed Revenue Adjustment $	G = F*A	**-$60,153,549**
Total PAU %	H	9.77%
Total PAU $	I = A*H	$1,835,962,632
Required Percent Reduction PAU	J = G/I	-3.28%

*Does not include revenue from McCready, or freestanding EDs.
** Inflation factor is subject to revisions related to updated data and Commission approval

Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations regarding the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

This test requires the Model to generate $300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital-only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were summed to determine total *hospital* savings. The TCOC Model requires that the State reach an annual total cost of care savings of $300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance overtime to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2021 estimated performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual savings requirement of $222 million for performance year three (CY 2021). However, while the State has favorable savings for CY 2021, guardrail performance when compared to the nation is expected to be unfavorable, with Maryland growing faster than the nation in 2021. Final CY 2021 data is in the process of being reconciled and approved with CMS and will be released at a later date, but staff anticipate that the State will miss the guardrail target by greater than 0.5 percent. Similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach whereby prior year national trend was used to estimate national trend. However due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails in RY 2022. For RY 2023 staff is

using a similar approach as the prior year trend is, once again, not likely to be an accurate reflection of future trends.

Actual revenue resulting from RY 2022 updates affect the CY 2022 results. As a result, staff must convert the recommended RY 2022 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2022 to assist in estimating the impact of the recommended update factor together with the projected RY 2023 results. The overall increase from the bottom of this table is used in Tables 6a-6c.

Table 5

Estimated Position on Medicare Test		
Actual Revenue CY 2021		18,951,788,063
Step 1:		
Approved GBR RY 2022		19,638,102,984
Actual Revenue 7/1/21-12/31/21		9,501,433,932
Approved Revenue 1/1/22-6/30/22		10,136,669,052
FY22 Undercharge in First Half of CY22		(125,000,000)
Anticipated Revenue 1/1/22-6/30/22	**A**	**10,011,669,052**
Step 2:		
Approved GBR RY 2022		19,638,102,984
Reverse One Time Extraordinary Adjustments:		(189,274,421)
Adjusted GBR RY 2022		19,448,828,563
Projected Approved GBR RY 2023		20,081,373,781
Permanent Update RY 2023		3.25%
Adjusted Change from GBR RY 2022		2.26%
Step 3:		
Estimated Revenue 7/1/22-12/31/22 (after 49.73% & seasonality)		9,986,467,181
CARES Act $ Payback		-
FY23 Inflation Advance Payback		(98,505,808)
FY21 Undercharge Release in Second Half of CY22		95,754,888
Projected Revenue 7/1/22-12/30/22	**B**	**9,983,716,261**
Step 4:		
Estimated Revenue CY 2022	**A+B**	**19,995,385,313**
Increase over CY 2021 Revenue		5.51%

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2021.

Step 1: The table uses global revenue for RY 2022 and actual revenue for the last six months for CY 2021 to calculate the projected revenue for the first six months of CY 2022 (i.e., the last six months of RY

2022). Hospitals currently project they will not be able to charge all of RY 2022 revenue by the end of the Rate Year, the estimated shortfall is $125 million (the RY 2022 Undercharge). The RY 2022 Undercharge is either (a) forfeited as penalties or (b) deferred and added to revenue as a catch-up in the first half of CY 2023, or some combination of the two, with the actual result varying by hospital. Under either scenario it does not impact CY 2022 revenue and is therefore subtracted in Step 1.

Step 2: This step begins with the approved revenue for RY 2022 and reverses out the extraordinary one-time adjustments from RY 2022 that were a result of the COVID-19 pandemic. These one-times include: RY 2020 GBR settle up, RY 2021 price variance, COVID surge funding, and RY 2023 advanced inflation funding. The result is an adjusted RY 2022 GBR. The proposed update of 3.25 percent, as shown in Table 2, is then applied to the adjusted RY 2022 GBR amount to calculate the projected revenue for RY 2023.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2023 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2023. Additionally, staff applied the RY 2023 Advanced Inflation payback and release of the remaining RY 2021 undercharge to determine the projected revenue for the final six months of the calendar year.

Step 4: This step shows the resulting estimated revenue for CY 2022 and then calculates the increase over actual CY 2021 Revenue. The CY 2022 increase based on this year's recommended update is 5.51 percent. The 5.51 percent is used to estimate CY 2022 hospital spending per capita for Maryland in our guardrail calculation, which is explained next in this policy.

Consistent with prior commitments, staff are reviewing an additional wave of Covid surge funding for RY22 and expense funding for RY20 and RY21. At this time, it is not recommended that any funding be added in July. Staff will work with stakeholders to refine the methodology for the COVID wave that occurred in RY 2022. Any additional funding would be implemented at a later date and will consider the impact on calendar year guardrail tests.

Staff modeled three different scenarios to project the CY 2022 guardrail position. Each scenario is described in more detail below. The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, staff applied the estimated CY 2022 growth of 5.51 percent, shown in Table 5 to Maryland hospital spending per capita from 2021. The Maryland hospital growth estimate takes into account available hospital specific factors, such as the estimated RY 2022 Undercharge, remaining RY 2021 undercharge release and advanced inflation payback. Tables 6a-6c below show the results of these analyses. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 6a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2021 as the base. This is a similar trend that staff used to predict 2021 growth, with an updated base.

Table 6a

Scenario 1 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,742	$11,974	Predicted Variance
YOY Growth	4.99%	3.88%	1.12%

Scenario 2, shown in Table 6b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend from 2015 - 2019 and trends the data forward using 2021 as the base. This is the most conservative estimate of the three scenarios. Staff added this scenario because the trend used in Scenario 1 proved to be higher than actual trend in CY 2021 and resulted in an overestimate of national growth. Utilizing a longer period to establish the "typical" trend results in a lower trend estimate, as the more recent 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 6b

Scenario 2 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,696	$11,850	Predicted Variance
YOY Growth	4.64%	2.80%	1.84%

Scenario 3, shown in Table 6c, utilizes the 2022 projection as published by the Office of the Actuary which is predicted to be 7.10 percent for 2022. The non-hospital portion of Maryland estimate utilizes the OACT growth prediction of 7.1 percent. The draft recommendation used a national growth estimate of 5 percent. Staff derived that amount by using figures provided in the National Health Estimate (NHE) tables. The 5 percent matched OACT figures for CY 2023. After further review and discussion with OACT, 7.1 percent is the best growth estimate to use for CY 2022. . Hospital and non-hospital is not broken out in the updates provided to staff. Staff believes 7.1 percent is the best estimate to use, but have some concerns that this may be too low of a growth to use for Maryland non-hospital because Maryland has historically trended higher than the nation. There is considerable variation among staff's three national trend forecasts - high (7.10 percent) and low (2.8 percent). This illustrates considerable uncertainty about how health care costs

will "bounce back" as the healthcare market incorporates the COVID-19 pandemic window into the future patterns of care.[1]

Table 6c

Scenario 3 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,927	$12,345	Predicted Variance
YOY Growth	6.41%	7.10%	-0.69%

In addition to modeling the CY 2022 guardrail position, staff also modeled estimated savings under each scenario. The savings target for CY 2022 is $267 million. Achieving an annual run rate of $267 million in CY 2022 is crucial as we move to the next phase of Model negotiations because this year will serve as the basis for the federal government's evaluation of the Model. Tables 7a-7c below highlight our annual savings or dissavings and anticipated 2022 run rate under each scenario.

Scenario 1 and Scenario 2 estimate that Maryland would miss the savings target for CY 2022, while under Scenario 3 Maryland would achieve the target. This range of outcomes illustrates the considerable uncertainty in the national projections. Staff want to note that there are significant negative consequences to missing the savings target in CY 2022.

Of note, the final line item in Table 7a and Table 7b estimate CY2022 savings if we applied the MPA-SC (Medicare Performance Adjustment - Savings Component) to the Medicare portion of the remaining undercharge that will be released in July rate orders. Staff believe that invoking this option would be a path of last resort. In addition, staff believes that the only revenue that would be appropriate to have this applied to would be one-time revenue adjustments, as application to permanent revenue would undercut the all-payer nature of the Model.

[1] During the workgroup process around this recommendation hospital stakeholders suggested using the US Per Capita Cost trends used to project Medicare Advantage increases. This methodology estimates a much higher 9 percent growth for the nation for CY 2022. Staff have concerns about differing from the national estimate that is provided by OACT, which the HSCRC has used as a reference in past years, given that these are projections and there is considerable uncertainty regarding the likely bounce back. As discussed above the approach used in Scenario 1 proved to be an overestimate in CY 2021.

Table 7a

Scenario 1 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$110 M
2022 Savings (Run Rate)	$228 M
2022 Savings with One-Time Revenue Adjustments Removed	$263 M

Table 7b

Scenario 2 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$192 M
2022 Savings (Run Rate)	$146 M
2022 Savings with One-Time Revenue Adjustments Removed	$181 M

Table 7c

Scenario 3 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Savings	$72 M
2022 Savings (Run Rate)	$410 M

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the Gross State Product. The purpose of this modeling is to ensure that healthcare remains affordable in the State. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GSP numbers available (CY18-CY21). The 3-year CAGR calculation shows a per capita amount of 2.22 percent. Staff then compared that number to the 3-year CAGR for Hospital Acute Charges using (CY18-CY22). Staff was able to estimate CY 2022 charges using the proposed RY 2023 update factor. The CAGR for hospital charge growth equated to 3.59 percent. Staff also calculated a 5-year CAGR calculation, shown in Table 8b. The difference between 5 years of Gross State Product and Hospital Acute charges show a variance of 0.69 percent. The charts below show these comparisons. While unfavorable, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution. Moreover, given the unprecedented increases in inflation over the past year that have yet to prove temporal, staff do not believe

it is prudent to use prior affordability assessments as a hard cap on global budget revenue allotments in RY 2023.

Table 8a

GSP (2018 - 2021)	Hospital Charges (2019-2022)	Variance
2.22%	3.77%	1.55%

Table 8b

GSP (2016 - 2021)	Hospital Charges (2017-2022)	Variance
2.52%	3.21%	0.69%

Medicare's Proposed National Rate Update for FFY 2023

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 18, 2022. In the proposed rule, CMS would increase rates by approximately 3.20 percent which includes a market basket increase of 3.10 percent, a productivity reduction of -0.40 percent, and a legislative increase of 0.50 percent. This proposed increase will not be finalized until August 2022 and will not go into effect until October 1, 2022. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Inflation Reconciliation Proposal

Staff's draft recommendation of the update factor utilized a lower national growth projection. The final recommendation utilizes an updated growth projection for CY 2022. After further review of inflation funding, staff determined that hospitals have been underfunded over the course of the pandemic by approximately 0.40 percent. As a result of these two changes, staff has updated the recommendation to include an additional 0.40 percent for inflation reconciliation to be added on July 1, 2022. At this time staff do not recommend providing any additional inflation beyond the 0.40 percent in this rate year, as it would not be tied to any methodological approach. Staff are committed to continuing to monitor inflation and review Maryland growth compared to the nation for the remainder of the calendar year. In addition, now that this type of adjustment has been incorporated into the process, Staff recommend the Commission consider this retroactive evaluation every year and apply an adjustment to current year inflation if the variation is material, regardless of the direction of the adjustment

The annual update factor relies on an estimate of the inflation for the future period being funded. As a result, the approved Update Factor could over- or under-fund inflation for a given period versus the actual experience for that period.

The Commission has not historically adjusted for this because amounts are often small and adjusting inflation for prior estimation error would add additional complexity to the update factor process, it is likely that under- and over-estimates will cancel out over time, and the Commission's mandate is to provide financial stability and not a margin guarantee. Therefore, it is not necessary to exactly fund inflation in every period, as hospitals can bear some risk for variations between funding and inflation.

Hospital stakeholders have argued that because the inflation estimate used in the RY 2022 update factor was a significant underestimate of actual inflation the Commission should depart from historic practice and provide additional inflation, a "catch-up", in RY 2023, in order to fund full inflation on a permanent basis.

The Commission and staff have been watching inflation and wage and labor cost pressures carefully. In response to concerns raised by the hospital field around rising labor costs, the Commission advanced a one-time increase of $100 million in January 2022, and accelerated the release of prior year undercharges. Additionally, the Governor also made available $30 million to hospitals to support unusually high workforce costs. Finally, an additional $50 million is anticipated to be awarded from the State to hospitals in RY 2023 to further cover workforce demands that have sustained through the year. While these are one-time adjustments to hospital rates, they do provide financial support to hospitals in the short term until more is understood about the permanency of those labor cost increases.

While staff acknowledge that the shortfall of permanent inflation for RY 2022 was much more significant than the variance in prior years, staff are not recommending the Commission reverse historic practice and adopt a catch-up adjustment greater than .40 percent as of July 1, 2022, because of the availability of extraordinary one-time funding available to hospitals in RY 2022 as mentioned above, pressure on the Medicare guardrail and savings tests documented above, as well as uncertainty surrounding national growth trends.

Instead, staff recommend that the Commission direct staff to convene a stakeholder workgroup and report back to the Commission in November 2022 on (a) a policy for addressing differences between actual and estimated inflation in future update factors within the parameters outlined below (or that such a policy is not required) and (b) a recommendation to the Commission for a reconciliation inflation adjustment for experience through RY 2022 to be applied to hospital rates on January 1, 2023, consistent with the policy developed under item (c), and with the State's savings position and other factors considered in the typical annual update factor process. Staff's bias is that such an adjustment is appropriate but the feasibility of providing such adjustment and the size of the adjustment will depend on the State's savings position, national growth rates and the policy parameters described for the general policy and that by waiting for January 1, 2023, to apply any adjustment the Commission will have better information on these factors.

The possible parameters for the general policy described in (a) above are:

1. That any policy is two-sided and would apply to both over and underestimates of inflation

2. That any policy looks at cumulative inflation over or under funding since 2013, including consideration of the impact of the PAU inflation adjustment, the infrastructure funding and other permanent funding adjustments as applicable
3. That any policy would have a materiality provision such that an adjustment would only apply when the cumulative under or overfunding of inflation reached a specified threshold (e.g., 0.75 percent)

Stakeholder Comments

In a series of meetings beginning in early CY 2022, HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2023 update.

MHA submitted a proposal that outlined the requested increase of their members. The following hospitals also submitted comment letters in support of MHA's letter: Luminis Health, University of Maryland Medical System, Johns Hopkins Health System, Holy Cross Health, MedStar Health, Acension St. Agnes, and Sheppard Pratt. MHA's request in their official comment letter did not differ from their request from their comments during Payment Models. Comments are outlined below with staff's response in italics:

1. Fund IHS Market's RY2023 cost inflation, expected to be at least 3.58%
   Staff agree and have updated our tables and projections to include the release of the First Quarter Book from Global Insights. The inflation amount of 3.66 percent is reflected in this recommendation.
2. Make the $100 million advance funding permanent, requiring no repayment
   Staff does not agree. This advance was always intended and communicated that it was to be paid back. In addition, hospitals have received $80 million from the Governor over the last two fiscal years. The advance amount of $100M was not based on any specific inflation information. Staff have proposed an adjustment based on an analysis of historic inflation data and staff does not believe making a temporary, stopgap, advance permanent is appropriate in lieu of or in addition to an inflation adjustment based on a reasonable methodology.
3. Modify the savings adjustment for potentially avoidable utilization (PAU): A) Set rewards and penalties around a base of 0 percent, measuring year-over-year change; B) Set a statewide average benchmark as hold harmless floor, and apply adjustments to hospitals that exceed the benchmark; and C) Use a national benchmark to set a PAU savings target
   Staff believe that the proposal has merit since global budgets already have an incentive to reduce PAU and PAU inflation cannot theoretically be defunded in perpetuity without adversely affecting core inflation for non-PAU services. However, this assertion rests on the notion that hospitals, primarily due to the incentives of the global budgets, have successfully eliminated almost all avoidable utilization, even independent of the current definition of PAU (30 day readmissions and acute exacerbations of chronic conditions). To date, no data has been provided to suggest that Maryland has grossly surpassed current national performance on current definitions of PAU or other definitions not yet reflected in payment policy (excess imaging, canonical examples of low value care - knee arthroscopy for individuals with osteoarthritis, etc). Therefore, to discontinue the

PAU savings adjustment, especially in a year where TCOC guardrails and savings are a concern, does not seem prudent, but staff defer to the judgment of the Commission.

4. Limit the projected reduction in uncompensated care funding
   Staff do not agree. The uncompensated care policy has historically relied on a retrospective statistic of uncompensated care to determine funding. This approach has provided higher than anticipated levels of uncompensated care as the Affordable Care Act and other factors, e.g. lower unemployment, steadily reduced charity care and bad debts. Thus, staff do not believe it is appropriate to stray from policy in this year purely based on the assertion that uncompensated care will increase due to sunsetting federal stimulus payments. Furthermore, staff believe that the large decline in UCC levels may be due to changing practice patterns that result in an increased utilization of telemedicine, urgent care centers, and other alternatives to emergency room care. As such, staff do not support this request because UCC levels may not rebound.
5. Monitor inflation and Model performance for six months and adjust rates effective January 1, 2023, if conditions permit.
   Staff are committed to working with a workgroup to determine if any additional funding will be appropriate on January 1. Our proposal is outlined in this recommendation, but staff would note additional inflation in RY 2023 is unlikely since the Final Recommendation outlines an additional .40 percent increase to recognize recent underfunding of actual inflation.

In addition to the request outlined above, MHA proposed using a much higher national growth estimate when trending forward 2022. These growth rates of 9 percent were mentioned earlier in this recommendation. *Staff do not believe it is appropriate to stray away from the OACT for the national growth projection and the internal projection approaches based on recent trends used in prior years. Office of Actuary projections are projected for Fee-for-Service. The USPCC projections cited by MHA are used in projection MA (Medicare Advantage) increases. In addition, staff have had conversations with the Office of the Actuary to determine the most appropriate source to use when determining projected cost growth for the following year. It was determined through those conversations that the growth projections provided by the Office of the Actuary for the President's Budget are the most appropriate projections to use.*

Medicaid provided comments that supported staff's draft recommendation for three main reasons:

1. Maryland can't risk becoming subject to a corrective action plan for failing to meet the TCOC Model Guardrail test.
   Staff agrees. In the penultimate year of this demonstration it is incredibly important to ensure that the update remains within the bounds of projected calendar year growth. Staff has worked hard during this process to determine the appropriate national growth projection and will not recommend an update that does not provide some cushion.
2. Medicaid does not agree with MHA's comment that the $100 million inflation advance should be made permanent and should not be paid back.
   Staff agrees.
3. Medicaid served as a safety net during the pandemic, absorbing an increase of 20 percent increase in coverage and agrees that the UCC adjustment is appropriate.
   Staff agrees.

CareFirst agreed with staff's draft recommendation, but had several concerns, which are outlined below.

1. CareFirst noted that any increase as a result of the Update Factor gets passed on to employers. In addition, they expressed concern that mid-year rate increases can't be accounted for in MA and MCO plans.
   Staff recognizes the concerns it may place on payers by having mid year rate increases. We understand that RY21 was a significant increase at mid-year and do try to limit such increases. Staff have revised our proposal to provide a fixed increase as of July 1, thereby significantly reducing the likelihood of providing additional inflation in January.
2. CareFirst expressed concern that two of the guardrail/run rate scenarios that staff created project Maryland to grow faster than the Nation, explicitly stating concerns over staff's non-hospital projection. It was also noted that the undercharge assumption may not carry forward to June. It was urged that staff pressure test these assumptions prior to finalizing the recommendation.
   Staff created over 10 different guardrail and savings scenarios while evaluating potential guardrail positions. The three that were presented were the most realistic outcomes based on extensive review of data and past trends. The biggest obstacle to overcome each Update Factor season is projecting what will happen with national growth. Staff have had conversations with the Office of the Actuary to determine the most appropriate growth estimate and determined that the projections from the President's Budget are the best estimate. In addition, staff recognize that there are a number of factors that impact this year's update, including the projected FY 2021 undercharge. Staff are releasing the final recommendation with updated undercharge projections with data through April 2021.
3. CareFirst noted that staff's 'affordability' test comparing three years of hospital charge growth to a three-year GSP trend yields unfavorable results. The impact of which gets passed on to employers and health plans.
   As noted above, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution.

Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following final recommendations for the RY 2023 update factors.

For Global Revenues:

(a) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs. Furthermore, provide an additional 0.40 percent to account for the underfunding of inflation through the pandemic from FY 2020 - FY 2022

(b) Provide an overall increase of 3.25 percent for revenue (including a net change to uncompensated care) and 3.38 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

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

(a) Provide an overall update of 3.66 percent for inflation and an additional 0.40 percent to account for the underfunding of inflation through the pandemic for FY 2020-FY2022.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Appendix A: Reconciliation of Set Aside for RY 21 and RY 22

As part of the RY 2022 recommendation, Commissioners requested that staff provide a reconciliation of previous years set aside funding. Below is an overview of this request for RY 21 and RY 22.

Distribution of Set Aside for RY 2021			
RY 2021 GBR Revenue		$19,105,021,605	
Set Aside %		0.25%	
Set Aside $		$47,762,554	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**
Mercy	$15,000,000	0.08%	Integrated Efficiency
Suburban	$11,933,939	0.06%	Integrated Efficiency/Capital
Shock Trauma	$2,564,524	0.01%	Shock Trauma Standby
Anne Arundel	$5,270,679	0.03%	Cardiac Program Funding
Statewide	$13,291,872	0.07%	Statewide Vaccination Adj.
Total	$48,061,024	0.25%	

Distribution of Set Aside for RY 2022			
RY 2022 GBR Revenue		$19,638,102,984	
Set Aside %		0.25%	
Set Aside $		$49,095,257	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**
Fort Washington	$6,253,680	0.03%	Integrated Efficiency
Howard County	$12,500,000	0.06%	Integrated Efficiency
Holy Cross	$8,704,705	0.04%	Integrated Efficiency

Anne Arundel	$1,364,501	0.01%	Cardiac Program Funding
Garrett	$2,072,192	0.01%	New Services: LIT, Pain Mgmt, Pop Heath.
Dorchester	$3,400,000	0.02%	Integrated Efficiency
Sinai	$5,500,000	0.03%	Integrated Efficiency (one-time)
PRMC	9,300,179	0.05%	Population Health, Behavioral Health, & Integrated Efficiency
Total	$49,095,257	0.25%	