Final Recommendations for a Capital Financing Policy

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This document includes the final staff recommendation for a Capital Financing Policy.

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Introduction

Since 2014, the State has operated under a per capita constraint imposed by the Centers for Medicare and Medicaid Services (CMS) as a condition of the All-Payer Model and the Total Cost of Care (TCOC) Model. The Commission has set the Global Budget Revenue (GBR) for hospitals and the annual update factor to manage the per capita growth rate. The GBR limits a hospital's incentive to grow volume unnecessarily. However, volume growth combined with HSCRC rate support were historically used to finance new capital projects, creating an inherent tension between the incentives of the TCOC Model and the ability to generate sufficient revenue to replace aging facilities.

Stakeholders have thus expressed concern that there is no defined or predictable route for hospitals to receive additional money for new capital projects under the GBR methodology. This recommendation establishes a policy to provide predictable rate updates for new capital projects, while also taking into account increased excess capacity produced by volume declines over the past 5 years and the inefficient use of fixed costs. Therefore, staff recommend that the rate updates for capital financing be scaled by the hospital's efficiency and excess capacity. The following final staff recommendation takes into account stakeholder feedback and staff work on an appropriate policy to fund capital projects under the TCOC Model.

Recommendations

Staff recommend that rate support be limited to capital projects that exceed a threshold of 25 percent of permanent revenue for hospitals that have a permanent revenue base of $300 million or greater. For smaller hospitals with permanent GBR revenue less than $300 million, the threshold will be scaled up to 50 percent of the hospital's permanent revenue. Further, the amount of funding for which a hospital's capital project is eligible should be determined through the following three-step algorithm:

- Determine the Hospital's eligible funding based on the proposed project
- Apply a scaling factor based on efficiency
- Adjust for PAU and excess capacity

Staff further recommends that the amount of funding determined by the algorithm be added to the hospitals permanent revenue beginning in the year in which a capital project comes online. In that year, staff will recommend that the amount of the capital project be subtracted from the inflation portion of the update factor, if the update factor inclusive of capital funding would cause Maryland to exceed the Medicare total cost of care guardrail tests or the growth in the gross state product (GSP).

Finally, if a hospital applies for a rate increase for a project after the conclusion of the Certificate of Need approval process, staff recommends that the amount of funding they receive should be equal to the lesser of the algorithm when the hospital submits a rate request and the year that the project was approved through the Certificate of Need process.

Capital Funding under a Total Revenue Constraint

Predictability in capital funding is important not just for hospitals but also for the Commission to manage the various total revenue constraints incorporated in the Total Cost of Care Model, as capital projects could increase costs suddenly when they come online. If a very large project or several simultaneous projects come online, the increase in costs could endanger the State's annual total cost of care guardrail test, as well as its annual total cost of care savings rate test.

Staff, therefore, considered limiting the amount of capital funding that could be distributed in any given year, which would require hospitals to potentially wait until the system could afford capital funding. However, the staff also believe that the two-pronged test used to set the hospital update factor, which limits growth to be less than both Maryland Gross State Product (GSP) growth and national Medicare growth guardrail tests, is a sufficient limitation on hospital cost growth. If the update factor would cause Maryland to exceed either GSP growth or national Medicare growth guardrail tests, then the amount of capital funding will be subtracted from general inflation in the update factor. But should the update factor – inclusive of capital funding – comply with the lesser of test then the staff do not recommend that an adjustment should be made to inflation.

In order to avoid a large growth in capital costs and to ensure that hospitals utilize retained revenues related to avoided utilization to finance smaller projects, staff recommend that a rate update be limited to projects whose value exceeds at least 25 percent of a requesting hospital's permanent revenue base. Staff considered limiting rate increases to projects that exceed the greater of 25 percent of a requesting hospital's permanent revenue base or $50 million. However, $50 million will exceed the permanent revenue of several small hospitals. Therefore, staff recommend limiting the applicability of rate increase for capital based on a percentage of the hospital's permanent revenue but scaling the threshold based on the size of the hospital. Staff recommends using permanent revenue instead of the annual GBR because certain allocated costs (such as the deficit assessment) can be large but are not available for funding capital.

The staff recommend maintaining the threshold for a project to receive capital funding at 25 percent of the hospital permanent revenue for a hospital near or above the median of all hospitals (about $300 million). Staff also recommend increasing the capital threshold by 0.10 percent for every million dollars that the hospital is below $300 million. This equates to scaling from a threshold of 25 percent for a hospital with permanent revenue of $300 million to a threshold of 50 percent for a hospital with permanent revenue of $50 million. For example, a hospital with permanent revenue of $200 million would have a capital threshold of 35 percent or $70 million dollars. The table below shows the capital threshold and the threshold amounts in increments of $50 million. While the threshold is a higher percent of the hospital's permanent revenue base, the actual dollar value of the threshold is lower for smaller hospitals. A hospital with a permanent revenue base of $50 million would have a threshold of only $25 million, down from the original recommendation of $50 million.[1]

Permanent Revenue	Threshold for Capital Funding	Threshold Amount
> $300,000,000	25.0%	$75,000,000
$250,000,000	30.0%	$75,000,000
$200,000,000	35.0%	$70,000,000
$150,000,000	40.0%	$60,000,000
$100,000,000	45.0%	$45,000,000
< $50,000,000	50.0%	$25,000,000

Staff believe this will continue to limit applications for capital funding to large projects that could not be financed without rate support, primarily projects that include building new physical plants, while at the

[1] See Capital Threshold Calculator in Capital Methodology Workbook to determine if a project meets the threshold for rate support.

same time recognizing the smaller hospitals do not have the same level of capital reserves to finance projects that are large relative to their size. Smaller projects, i.e. less than the proposed scaled thresholds for capital funding listed in the above table, should be financed out of existing revenues. Hospitals currently receive funding for capital projects in the annual update factor and hospitals retain the average annual interest and depreciation costs on all their previous capital projects, even after those projects have completed their useful life.

Staff considered lowering the threshold for larger hospitals but did not recommend doing so for two reasons: first, capital is already funded through the update factor and projects smaller than a major plant replacement should have sufficient funding; and second, larger hospitals likely have additional financial flexibility to fund projects, such as philanthropy or large cash balances.

Additionally, staff recommend establishing a policy for when partial rate applications can be considered. When applying for a Certificate of Need for a capital project, a hospital must indicate whether they are seeking a rate update to cover a portion of the costs. A hospital is not required to seek a rate update and may delay doing so until a later date. However, staff are recommending a financing formula based on the ICC and Medicare total cost of care (TCOC) growth, both of which may change overtime. In the event that a hospital delays applying for a rate increase to cover the capital costs, staff recommends that the amount of capital funding they can receive be equal to the lesser of the calculation when the hospital certificate of need was approved and when the hospital actually applies for the capital funding.

Algorithm to Determine Capital Financing

Staff recommend a three-step algorithm to calculate the rate increase that a hospital can receive in order to finance a capital project. The three steps are:

1. First, determine the amount of a capital project that will be supported through rates.
2. Second, scale the amount of funding that a particular hospital will receive for its capital project by determining its relative capital efficiency as well as that hospital's ICC and TCOC efficiency.
3. Third, credit/penalize hospitals based on their potentially avoidable utilization (PAU) and excess capacity in order to ensure that efficient hospitals are funded while inefficient hospitals finance new capital through other cost reductions.

Step 1: Determine the Hospital's Maximum Eligible Funding

Staff will calculate the average annual depreciation costs of the hospital's project using the straight line method with the hospital's estimate of the project's useful lifetime. Staff will also calculate average annual interest on 100 percent of the project's value for establishing initial eligible funding. If the output of the capital methodology exceeds 70 percent interest, staff will cap rate support to 100 depreciation, 70 percent interest. By financing only 70 percent of the project's value, the staff expects that at least 30 percent of the project be paid by the hospital either through cash, philanthropy, or other sources of funding that are not direct rate support. Staff will calculate the hospital project's estimated average annual interest payments at the effective annual interest rate at which the project is expected to be financed.

Step 2: Apply a Scaling Factor based on Efficiency

Step 1 above determines the maximum amount of capital funding that the hospital could receive on a project, however, staff recommends that a hospital be eligible to receive only portion of that amount,

depending on its relative efficiency. The staff recommends using two measures of efficiency: the hospital's capital efficiency and the hospital's integrated cost per case and total cost of care efficiency.

The hospital's relative capital efficiency is taken into account by taking the portion of total costs the hospital spends on capital and comparing it to its peer group. The hospital is only eligible to receive the average of its capital costs (inclusive of the new project) and its peer group average. Comparing a hospital to its peer group will discourage hospitals that may be already more capital intensive than their peers from building additional capital projects. Alternatively, this process will provide credit to hospitals that are further in the capital cycle and therefore have greater need for a capital replacement project.

To measure integrated cost per case and total cost of care efficiency, staff employs the ICC and a Medicare total cost of care growth calculation. The ICC measures the efficiency of the hospital's cost per case relative to its peer group and in the case of capital evaluations does not include productivity adjustments, per historical practice. The ICC's productivity adjustment was intended to eliminate costs related to excess capacity. Staff believe it is critical to address excess costs when financing capital in order to avoid rebuilding or increasing excess capacity with a new project. Therefore, staff recommends that excess capacity costs be addressed directly rather than through the ICC's productivity adjustment and subsequent relative ranking. The excess capacity adjustment is described in Step 3.

The ICC is an important consideration for capital financing for two reasons. First, it ensures that hospitals that are using existing fixed costs efficiently receive more financing than hospitals that are using fixed costs less efficiently. Second, it ensures that hospitals with lower profit margins and more efficient costs receive more financing than hospitals with more significant profit margins that could more easily fund capital projects with existing rate structures.

In terms of total cost of care, staff is currently employing Medicare total cost of care growth using a geographic attribution relative to a 2013 base. It is important to use a 2013 base because growth calculations are more statistically reliable with multiple years of data and because the incentives of the Models since 2013 were to reduce total cost of care in line with the annual total cost of care guardrail tests. Because staff believes it is necessary to use growth relative to a 2013 base, the geographic attribution is necessary. That said, staff will consider supplanting the growth calculations with attainment analyses relative to nationally selected benchmarks once this work is complete.

Step 2A: Compare the Hospital's Requested Capital Costs with its Peer Group

Staff will adjust the amount of funding that the hospital can receive based on the average capital intensity of the hospital's peer group. The adjustment is necessary to ensure that hospital's that are already more capital intensive than their peers do not become more so and also to ensure that hospitals that have not recapitalized in some time have the opportunity to do so.

The adjustment is calculated as follows.

- First, staff will calculate the percent of the hospital's operating costs that will be spent on capital[2] (Hospital Pro Forma Capital Ratio) if the hospital received the full amount of its eligible funding. That is, the staff will take the hospital's current capital costs and add the amount of funding the hospital has requested and divide the sum by the hospital's operating cost structure inclusive of the new capital request.

[2]The sum of average annual interest costs and depreciation

- Second, staff will calculate the percent of current capital costs for the hospital's peer group as a percent of revenue (Peer Group Capital Ratio). Staff will then deduct the current capital costs ratio from the average of the hospital's Pro Forma Capital Ratio and the Peer Group Capital Ratio. Finally, staff will result the prior step by current total operating costs to yield capital funding without Integrated Efficiency scaling.

Step 2B: Scale the Hospital's Eligible Funding based on its Capital ICC Score

The Staff will determine the hospitals relative rank on both the ICC and Medicare TCOC growth. Staff will equally weight the ICC and the Medicare TCOC growth rate by summing of the hospital's rank on each of the two scores. This Total Rank will be used to scale the amount of capital funding that the hospital can receive.

Staff will calculate a scaling factor based on the hospital's total ranking relative to other hospitals in the State through a two-step process.

- First, a hospital receives a base efficiency factor depending on the quintile in which the hospital falls. The most efficient quintile (lowest score) receives a base efficiency adjustment of 80 percent and the least efficient quintile receives a base efficiency adjustment of 0 percent.
- Second, the hospital receives an adjustment based on the variation in efficiency within its quintile.

The adjustment within the quintile is calculated by dividing 20 percent by the number of hospitals within the quintile and then multiplying by the hospitals within quintile rank. The adjustment within the quintile is necessary because the number of hospitals within each of the quintiles vary and because without such a calculation the policy can run afoul of adverse cliff effects. For example, there are 10 hospitals in the first quintile and so each rank is worth 2 percentage points; there are 9 hospitals in the second quintile so each rank is worth 2.2 percentage points. Without an adjustment within the quintile the 10th hospital in the quintile and the 1st hospital in the second quintile would have a difference of 20 percent for efficiency scaling as opposed to 0.2 percent. The following table summarizes the calculation:

Quintile	Base Adjustment	Within Quintile Adjustment
Q1	80%	+ (20% / # hospitals within quintile) x hospitals rank within quintile
Q2	60%	
Q3	40%	
Q4	20%	
Q5	00%	

Once the scaling factor has been calculated, it is multiplied by the amount of funding that the project is eligible for following capital efficiency scaling, as calculated in Step 2a. For example, the most efficient hospital in the third quintile would could receive up to 60 percent of the eligible amount of its capital project.

Table 1: Efficiency Adjustment by Hospital based on FY2020

Hospital	Efficiency Adjustment	Hospital	Efficiency Adjustment
Anne Arundel	100%	**MedStar Union Hospital**	73%
Atlantic General Hospital	98%	**Mercy Medical Center**	84%
Bon Secours Hospital	11%	**Meritus Medical Center**	91%
Calvert Memorial Hospital	42%	**Northwest Hospital Center**	24%
Carroll Hospital Center	36%	**Peninsula Regional**	64%
Doctors Community Hospital	67%	**Prince Georges**	62%
Fort Washington	73%	**Shady Grove Adventist**	32%
Frederick Memorial Hospital	78%	**Sinai Hospital**	40%
Garrett County Memorial	49%	**St. Agnes Hospital**	78%
GBMC	24%	**Suburban Hospital**	60%
Harford Memorial Hospital	89%	**Union Hospital of Cecil County**	9%
Holy Cross Hospital	82%	**UM Baltimore Washington**	89%
Howard County General	80%	**UM Charles Regional**	32%
Johns Hopkins Bayview	93%	**UM Medical Center**	18%
Johns Hopkins Hospital	96%	**UM Midtown Campus**	2%
Laurel Regional Hospital	73%	**UMROI**	13%
McCready Memorial Hospital	24%	**UM Chestertown**	18%
MedStar Franklin Square	44%	**UM Dorchester**	60%
MedStar Good Samaritan	4%	**UM Easton**	56%
MedStar Harbor Hospital	24%	**UM St Joseph**	20%
Montgomery Medical Center	7%	**Upper Chesapeake**	42%
MedStar Southern Maryland	53%	**Washington Adventist**	82%
MedStar St. Mary's Hospital	49%	**W. Maryland Regional**	51%

Step 3: Adjust for PAU and Excess Capacity

Staff recommend modifying the amount of capital funding the hospital can receive, as calculated by Step 2B, to account for potentially avoidable utilization and excess capacity. The dollar value of these two credits will be added to or subtracted from the amount of capital spending calculated in Step 2B in determining the final amount that a hospital is eligible to receive.

The PAU adjustment reflects the hospitals "opportunity" to reduce unnecessary utilization. Historically, hospitals financed a portion of their capital project through volume growth. That strategy is not viable under the GBR. Instead hospitals are expected to reduce unnecessary utilization (e.g. PAU) and reinvest the savings into capital and population health activities. However, hospitals that do not have as much PAU do not have as much opportunity to save money by reducing PAU. Therefore, staff recommend providing them with a credit for their capital projects.

The excess capacity adjustment reflects the decline in volume that has occurred in the hospital. The GBR allows hospitals to retain revenue as volume declines. Hospitals are expected to reinvest that revenue in capital or population health activities. A hospital that has experienced volume declines should be able to finance a portion of its capital project by eliminating the fixed costs that are no longer necessary to support a higher volume. Therefore, staff recommend subtracting the excess capacity costs from the amount of funding that a hospital can receive for a new capital project.

Step 3A: Potentially Avoidable Utilization (PAU) Adjustment

PAU is a measure of 30 day readmissions with various exclusions and avoidable hospitalizations for ambulatory sensitive conditions, as measured by Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs). The PAU adjustment is intended to make financing capital projects easier for hospitals that cannot use new projects to induce new demand and grow volume but also lack the opportunity to reduce potentially avoidable utilization as an alternative. Staff recommends basing the PAU adjustment on the ratio of the hospital's percent of revenue that is PAU to the statewide average percent of PAU revenue. The denominator for this statistic is inpatient revenue and observation greater than 24 hours, as PAU is not assessed in outpatient care.

This statistic and proposed adjustment reflects the hospital's opportunity to finance capital through reductions in potentially avoidable utilization relative to other hospitals. For example, a hospital with only 50 percent of the statewide average of revenue coming from PAU would have to reduce their rate of PAU utilization by twice as much in order to finance the same share of a capital project. Therefore, these facilities should receive favorable treatment in this policy.

The PAU adjustment is calculated in three steps.

- First, staff will calculate the statewide mean (18.44 percent) and standard deviation (6.55 percent) of revenue that comes from PAU across all hospitals. Any hospital whose PAU share of revenue exceeds the mean, does not receive a credit. Any hospital whose PAU share of revenue is less than the mean, receives a credit but it is capped at one standard deviation, i.e. 6.55 percent.
- Second, staff will calculate the difference between the hospital's rate of PAU and the statewide average rate of PAU and give credit equal to that difference.
- Third, staff will multiply that value by the efficiency scaling factor in Step 2A and multiply by the 50 percent Variable Cost Factor.

Table 2: PAU Credit Given by Hospital

Hospital	PAU% / State Avg	PAU Credit	Hospital	PAU% / State Avg	PAU Credit
Anne Arundel	96%	$1,172,968	**MedStar Union Hospital**	110%	$0
Atlantic General Hospital	133%	$0	**Mercy Medical Center**	71%	$5,484,507
Bon Secours Hospital	164%	$0	**Meritus Medical Center**	117%	$0
Calvert Memorial Hospital	120%	$0	**Northwest Hospital Center**	159%	$0
Carroll Hospital Center	141%	$0	**Peninsula Regional**	103%	$0
Doctors Community Hospital	146%	$0	**Prince Georges**	105%	$0
Fort Washington	176%	$0	**Shady Grove Adventist**	85%	$1,260,398
Frederick Memorial Hospital	107%	$0	**Sinai Hospital**	90%	$1,562,551
Garrett County Memorial	112%	$0	**St. Agnes Hospital**	139%	$0
GBMC	92%	$425,974	**Suburban Hospital**	81%	$2,342,323
Harford Memorial Hospital	154%	$0	**Union Hospital of Cecil County**	133%	$0
Holy Cross Hospital	82%	$5,920,797	**UM Baltimore Washington**	124%	$0
Howard County General	103%	$0	**UM Charles Regional**	123%	$0
Johns Hopkins Bayview	115%	$0	**UM Medical Center**	64%	$6,959,709
Johns Hopkins Hospital	81%	$25,639,623	**UM Midtown Campus**	149%	$0
Laurel Regional Hospital	114%	$0	**UMROI**	1%	$327,125
McCready Memorial Hospital	223%	$0	**UM Chestertown**	104%	$0
MedStar Franklin Square	133%	$0	**UM Dorchester**	141%	$0
MedStar Good Samaritan	165%	$0	**UM Easton**	76%	$1,377,575
MedStar Harbor Hospital	131%	$0	**UM St Joseph**	68%	$1,536,990
Montgomery Medical Center	121%	$0	**Upper Chesapeake**	130%	$0
MedStar Southern Maryland	129%	$0	**Washington Adventist**	105%	$0
MedStar St. Mary's Hospital	138%	$0	**W. Maryland Regional**	105%	$0

Step 3B: Excess Capacity Adjustment

Staff recommends removing the fixed costs associated with volume declines from the amount of capital funding that the hospital can receive for two reasons. First, excess and empty beds should not be rebuilt. And second, the savings from eliminating those excess costs are retained at the hospital and could be repurposed to finance new capital projects. The excess capacity adjustment is calculated in two steps:

- First, staff will calculate the difference between the 2010 patient days plus the 2013 OP surgery visits with a length of stay greater than 1[3] and current patient days, plus OP surgery visits with a length of stay greater than 1, and plus observation stays with a length of stay greater than 1.
- Second, staff have estimated the statewide fixed cost per bed day to be $1,201 dollars. The excess capacity adjustment is equal to $1,201 times the reduction in patient days since 2010. However, between 2010 and 2014, the State funded volume growth/declines at 85 percent for the variable cost. Under current policy, volume growth/decline due to market shift or deregulation is funded at 50 percent for variable costs. Therefore, the hospitals' excess capacity adjustment will be credited 35 percent for variable cost for volume declines that occurred

[3] Data on OP surgery visits only became available in 2013.

between 2010 and 2014, since that money has already been removed. Future iterations of this policy will recalculate this value.

The dollar values of the excess capacity adjustment will be subtracted from the cost of whatever capital funding the hospital would otherwise be eligible to receive. No adjustment is given to a hospital whose volume has remained the same or grown.

Table 3: Excess Capacity Adjustment by Hospital

Hospital	Change from 2010	Excess Capacity Adj.	Hospital	Change from 2010	Excess Capacity Adj.
Anne Arundel	7652	$0	**MedStar Union Hospital**	-19341	-$23,236,327
Atlantic General Hospital	-2384	-$2,864,144	**Mercy Medical Center**	-12517	-$15,037,956
Bon Secours Hospital	-17420	-$20,928,433	**Meritus Medical Center**	-4057	-$4,874,090
Calvert Memorial Hospital	-5818	-$6,989,760	**Northwest Hospital Center**	-3917	-$4,705,894
Carroll Hospital Center	-8213	-$9,867,119	**Peninsula Regional**	-17516	-$21,043,767
Doctors Community Hospital	540	$0	**Prince Georges**	-8313	-$9,987,259
Fort Washington	-3043	-$3,655,868	**Shady Grove Adventist**	-20086	-$24,131,372
Frederick Memorial Hospital	-1421	-$1,707,193	**Sinai Hospital**	-17953	-$21,568,780
Garrett County Memorial	-307	-$368,831	**St. Agnes Hospital**	-14317	-$17,200,480
GBMC	-7678	-$9,224,369	**Suburban Hospital**	5986	$0
Harford Memorial Hospital	-2299	-$2,762,024	**Union Hospital of Cecil County**	-9771	-$11,738,904
Holy Cross Hospital	-1024	-$1,230,236	**UM Baltimore Washington**	-9525	-$11,443,359
Howard County General	3033	$0	**UM Charles Regional**	-4557	-$5,474,791
Johns Hopkins Bayview	-6370	-$7,652,934	**UM Medical Center**	11025	$0
Johns Hopkins Hospital	37174	$0	**UM Midtown Campus**	-14959	-$17,971,781
Laurel Regional Hospital	-5288	-$6,353,017	**UMROI**	-1103	-$1,325,147
McCready Memorial Hospital	-1290	-$1,549,809	**UM Chestertown**	-7037	-$8,454,270
MedStar Franklin Square	-2027	-$2,435,243	**UM Dorchester**	-3105	-$3,730,355
MedStar Good Samaritan	-25685	-$30,858,025	**UM Easton**	-3887	-$4,669,852
MedStar Harbor Hospital	-15431	-$18,538,843	**UM St Joseph**	-13805	-$16,585,362
Montgomery Medical Center	-10183	-$12,233,882	**Upper Chesapeake**	-1507	-$1,810,514
MedStar Southern Maryland	-10847	-$13,031,614	**Washington Adventist**	-24083	-$28,933,378
MedStar St. Mary's Hospital	2506	$0	**W. Maryland Regional**	-13010	-$15,630,247

Once all calculations are completed, markup is applied to bring costs to charges.

Stakeholder Comments

Staff received six comment letters from stakeholders, e.g. Johns Hopkins Health System (JHHS), University of Maryland Medical System (UMMS), Adventist HealthCare, Greater Baltimore Medical Center (GBMC), CareFirst, and the Maryland Hospital Association (MHA). All comments were supportive of a dedicated capital policy.

JHHS, Adventist, and CareFirst support the use of the scaling factor for the amount of capital funding based on efficiency scores, using the ICC and the TCOC scores. UMMS, GBMC, and the MHA commented that scaling the capital funding based on efficiency is too limited and would restrict access to rate support. Staff believe that it is appropriate to adjust the amount of capital funding based on efficiency. The ICC indicates that hospitals' cost per case is relatively high, meaning that the hospitals have the opportunity to finance their capital project through improvements in internal cost efficiency. Several of

the commenters also suggested moving to an attainment based TCOC measure. The staff is exploring doing so, but recommends proceeding with this improvement in future policy iterations.

JHHS, UMMS, Adventist, GBMC, and the MHA expressed concern that the 35 percent or $50 million threshold to receive capital funding was too restrictive because projects that were smaller than a major plant replacement would not be eligible to receive funding. Staff agree that the threshold was too restrictive for small hospitals since $50 million would be greater than 100 percent of the hospitals permanent revenue for certain small hospitals. Staff's final recommendation includes a scaled threshold based on the size of the hospital. However, staff does not recommend changing the threshold for hospitals above the median size (about $300 million). Money for capital is currently available through the hospital's GBR and the update factor. Money added to rates for major capital projects would be double paying for those projects. Staff believes this is appropriate for major plant replacements, given the cash flow issues involved, but considers it fiscally prudent to exclude smaller capital projects from being eligible for rate increases on top of what is already provided through the GBR.

UMMS, Adventist, and GBMC, all expressed concern that the timing of capital intensity of the hospital's peer groups could effectively limit the amount of funding that the hospital could receive. Staff believe that the distribution of hospital costs within peer groups is relatively normal but do believe that the timing of a major capital project could change the peer groups capital intensity. The staff will monitor the timing of capital cycles within each peer group to assess the impact of adding new projects on other hospitals' eligibility for capital financing.

UMMS, Adventist, and GBMC, expressed concern with the calculation of the excess capacity adjustment. Until 2014, the State operated under an 85 percent variable cost factor (VCF), which means that volume declines between 2010 and 2014 have been partially defunded. Staff agrees with this concern and have recommended that a partial credit equal to 35 percent (the difference between the 85 percent VCF and the 50 percent VCF used to calculate fixed costs) be credited back to hospitals in the determination of the excess capacity costs.

Adventist expressed the concern that fixed costs cannot be rolled over to fund new capital projects because, by definition, those costs remain regardless of the quantity of goods and services that are provided. Staff agrees that building costs are fixed in the short-run but are not fixed when the hospital is constructing a new building. Therefore, staff consider it quite feasible that when replacing a building the hospital roll over some of their excess fixed costs.

The MHA expressed concern that the capital funding would be subtracted from the inflation portion of the update factor. CareFirst expressed support for doing so. The GBR already includes money for existing capital projects that remains in the hospital's budget after the project is fully depreciated and continues to receive the update factor. Additional money for capital is thus duplicative of that existing funding. However, staff believes that the current approach to the update factor – limiting the update factor to the lesser of GSP growth and national Medicare TCOC growth – is sufficient to constrain costs and therefore recommends that capital funding only be removed from the update factor if one of those two tests is jeopardized.

Recommendations

Staff recommend that rate support be limited to capital projects that exceed a threshold of 25 percent of permanent revenue for hospitals that have a permanent revenue base of $300 million or greater. For

smaller hospitals with permanent GBR revenue less than $300 million, the threshold will be scaled up to 50 percent of the hospital's permanent revenue. Further, the amount of funding for which a hospital's capital project is eligible should be determined through the following three-step algorithm:

- Determine the Hospital's eligible funding based on the proposed project
- Apply a scaling factor based on efficiency
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Staff further recommends that the amount determined by the algorithm be added to the hospitals permanent revenue beginning in the year in which a capital project comes online. In that year, staff will recommend that the amount of the capital project be subtracted from the inflation portion of the update factor, if the update factor inclusive of capital funding would cause Maryland to exceed the Medicare total cost of care guardrail tests or the growth in the gross state product (GSP).

Finally, if a hospital applies for a rate increase for a project after the conclusion of the Certificate of Need approval process, staff recommends that the amount of funding they receive should be equal to the lesser of the algorithm result when the hospital submits a rate request and the algorithm result in the year that the project was approved through the Certificate of Need process.