REPORT ON STATE SUPPORT

FOR PRIVATE HOSPITAL CAPITAL PROJECTS

Prepared by:

Department of Budget & Fiscal Planning

Division of Capital Budgeting

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As requested by the

Report of the Chairmen of the

Senate Budget and Taxation Committee

and

House Appropriations Committee

1993 Session

Capital Budget JCR: Page 37

EXECUTIVE SUMMARY

Current Process

- Grants to hospitals are now funded by bonds sponsored by individual legislators.
- The General Assembly approved 17 grants over the past 3 years, averaging $4.8 million per year.

Problems

- Projects are not subjected to uniform, systematic analysis.
- Hospital projects address very different needs from other local legislative initiatives. They should be evaluated through a separate process.
- The existing process does not assure that state grant funds are used to help promote statewide health policy priorities.

Proposal

- An annual $5 million in grants will be recommended for inclusion in the Governor's capital budget.
- Grants will be recommended by a committee of 7 hospital trustees, 4 hospital executives and a DBFP representative serving as an ex-officio member.
- Governor will consider recommendations before they are included in capital budget.
- To make room for the $5 million, the allocation for the legislative bond bills will be reduced by $2½ million, and other capital programs by $2½ million.
- Hospital projects included in state's 5-year capital plan will not go through the new process (currently major projects at UMMS and Johns Hopkins Hospital are in the 5-year plan).

Criteria

- Normal capital budget criteria (15-year useful life, at least equal matching funds, project ready to go, etc.).
- Health policy criteria (any CON, rate adjustments and other regulatory approvals must be completed; promotes state health policy goals such as primary and preventive health care services; favorable consideration for sole community providers, providers in underserved areas, statewide/regional services, and projects that facilitate mergers, consolidations, and down-sizing).
- Financial criteria (committee will consider a range of measurements of hospitals' financial capacity).

Exclusions

- Grants will not be considered for: new hospitals; projects that result in a net increase in inpatient beds; major medical equipment; parking facilities or other non-patient care-related facilities; or retroactive grants for work already completed.

BACKGROUND

Since at least as far back as 1962, the Maryland General Assembly has from time to time authorized capital grants to private hospitals. These grants have been allocated through the legislative bond bill process, and there has not been any mechanism for assessing the relative merits of proposed projects prior to the beginning of a legislative session.

In the past five years, legislative grants for hospital projects have become more frequent, and have grown in amount.

The Report of the Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee on the Capital Budget, 1993 Session stated:

> The committees are concerned about the growth in requests for state support for private hospital capital projects. The committees would like to see the development of a more orderly and systematic process for these projects. A unified process has worked well for the state's independent colleges and universities. The committees request the Department of Budget and Fiscal Planning to work closely with the Department of Health and Mental Hygiene, the Maryland Health Resources Planning Commission, the Health Services Cost Review Commission, and the Maryland Hospital Association to develop:
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> 1) An approximate amount of state support for private hospital capital projects to be requested each year;
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> 2) Criteria for the types of projects and costs eligible for state support;
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> 3) A process for evaluating individual hospital requests;

4) A system for developing a priority ranking and choosing projects for inclusion in the state capital budget; and

5) Recommendations for whether funding for an individual hospital project should be requested all at once or over the length of the project.

6) Recommendations for exclusion from this process.

The committees will expect a report by September 1, 1993.

This report is presented in response to that request.

Local hospital projects have generally been funded by individual bond bills introduced by legislators. The Governor allocates $15 million a year for such bills, and this allocation has to cover hospitals and other worthy projects. During FY 1989 - 1994 local hospital projects received a total of $17,250,000 in state funds, ranging from $150,000 in FY 1989 to $5,000,000 in FY 1993.

In response to the Joint Chairmen's Report a workgroup was convened. Neil L. Bergsman, from the Department of Budget and Fiscal Planning Division of Capital Budgeting (DBFP), served as chairman. The other members included: Elizabeth G. Barnard, Department of Health and Mental Hygiene (DHMH); Richard J. Coughlan, Health Resources Planning Commission (HRPC); Bernard Fox (DBFP); Lynn Garrison, Health Services Cost Review Commission (HSCRC); and Andrew Wigglesworth, Maryland Hospital Association (MHA). From time to time other officials of the represented state agencies also attended workgroup meetings.

This report was an end result of five meetings of the workgroup. The workgroup developed its recommendations through a consensus process with each member contributing equal input. The workgroup was also briefed by Elizabeth Garraway, Executive Director of the Maryland Association of Independent Colleges and Universities (MICUA) on MICUA's process for recommending state grants for private higher education institutions.

While the State workgroup was doing its work, MHA also convened a workgroup, to address this issue. After agreeing to a basic approach, the State workgroup asked the MHA workgroup to propose a specific application and review process.

DEFICIENCIES OF THE CURRENT PROCESS

The workgroup found three principal deficiencies with the practice of awarding grants to private hospitals through the legislative bond bill process.

First, there is no uniform and systematic process of evaluating capital grant requests from private hospitals. The review by the Department of Budget and Fiscal Planning provides a basic level of evaluation, but does not systematically factor hospital financial capacity, or the degree to which a proposed project promotes state health policy goals.

Secondly, the workgroup felt hospital projects addressed a very different set of needs

from most other "legislative initiative" projects. Hospital projects can and should be assessed according to a common set of criteria. A separate process would be more appropriate than the legislative bond bill process.

Finally, the workgroup felt that the State was missing an opportunity to use capital grants as a means of encouraging the furtherance of its broad policy goals in the area of health care.

PROFILE OF MARYLAND HOSPITALS

General

The Maryland Hospital Association's membership consists of virtually all hospitals in the state. Of the 68 member institutions comprising the MHA, 53 are acute care general hospitals with the balance specialty, long-term care, and veterans' hospitals. During 1992, Maryland hospitals served 637,489 inpatients, provided 8,938,579 outpatient visits, and delivered emergency care to 1,474,808 individuals. All but two of the acute general hospitals are private, non-profit institutions.

The size of Maryland hospitals ranges from a 47-bed institution in Frostburg to the 1,036-bed Johns Hopkins Hospital in Baltimore. The average Maryland hospital's size is 240 beds.

In addition to serving the health care needs of Marylanders, hospitals also contribute to

the economic health of their communities and the state. Hospitals employ more than 100,000 people statewide. About 40 of the state's top 200 employers are hospitals, with the two biggest hospitals in Baltimore employing more than 15,000. According to one study, in 1989 one out of every 34 employed Maryland citizens worked in a hospital.

Age and Condition of Facilities

The age of Maryland hospital facilities has been consistently older than the national median. The median age of hospital plants in 1991 was 7.93 years nationally versus 8.07 years in Maryland.

Current Capital Needs

Over the past decade, Maryland hospitals have averaged over $250 million per year for renovations, new construction or other capital improvements in their facilities. In light of the continuing advances in medical technology and changes in medical practice, the demands for capital improvements will continue.

How The Current Facilities Are Funded

By virtue of the state's unique all-payor rate regulatory system, hospital costs in Maryland are consistently lower than the national average--currently 14 percent below the national average. However, one of the trade-offs for this benefit is hospitals' ability to generate needed funds for capital improvements. Maryland hospitals are forced to rely on debt financing for capital needs to a greater degree than hospitals nationally.

In 1992, Maryland hospitals issued $275.8 million of bonds or long-term debt representing approximately 76 percent of all capital expenditures in that year.

Maryland hospitals' long-term debt to equity ratio median value in 1992 was 0.83 versus a median value of 0.61 for hospitals nationally. The portion of hospitals' assets funded by equity nationally is 52 percent versus 39 percent in Maryland. This heavy reliance on debt financing has been a major concern of Maryland hospitals and the Health Services Cost Review Commission.

MAJOR ALTERNATIVES CONSIDERED

The workgroup considered three major alternatives as to who would receive applications and make recommendations for requests for capital grants by the local hospitals.

The first alternative suggested was a private sector selection committee established by MHA, similar to the Maryland Independent Colleges and Universities Association (MICUA) model. The advantages of this type of model are that the MICUA process has been successful in higher education and in the workgroup's judgement such a model will have a good chance over time of being well accepted by the hospital industry. There was some concern about the lack of direct governmental input in the committee's deliberations. This disadvantage would be allayed by MHA's suggestion of including a DBFP representative as an ex-officio member of the selection committee.

A second alternative considered was to develop a committee of state officials. State policy objectives and the priorities of state agencies receive the greatest consideration under this process, and this model has been proven to be successful with community health facilities and public school construction. A major disadvantage to this alternative is that the hospital industry is less involved in the recommendation process.

The third alternative suggested was to develop a hybrid between a private selection committee and a committee of state officials. This public-private committee would accept advice and input from MHA in relation to the state process, thereby involving the hospital industry and addressing state agency priorities. This approach would attempt to craft a compromise between the first two models, but a specific recommendation was not developed. The workgroup was concerned that this approach would lead to a needlessly complicated process, that the roles of the various parties in the process would not be clear, and that responsibility for setting priorities and forming recommendations would be too diffuse. Moreover, the Committee noted that the proposed grants will ultimately be subject to review by DBFP and the Governor as well as the General Assembly.

CRITERIA

In considering alternatives, the workgroup applied the following criteria.

The recommended process should provide an adequate, reliable, and objective review of

capital projects.

It should provide the Governor and General Assembly with a recommended list of projects with clear, understandable justification and within the prescribed funding level.

It should achieve acceptance by the hospital industry and the General Assembly.

RECOMMENDATION

Review process

The workgroup recommended a selection process directed by the Maryland Hospital Association. It was felt that hospital trustees and health care executives would be best able to review the technical merits of proposed projects, and their relationship to the needs of the community and the health care system. DBFP would monitor the process to assure that State concerns were accorded proper weight, and to coordinate input and consultation from various state agencies, as appropriate.

Based on these broad parameters, the MHA Hospital Bond Projects workgroup proposed the following process, which the State workgroup has endorsed.

A. Governance/Review Committee

1. Membership

There shall be an 11-member committee to review and set priorities for

hospital bond projects. The committee shall be chaired by a hospital trustee. Of the 11 members:

a. 7 shall be hospital trustees;

b. 4 shall be hospital executives; and,

c. in addition, a representative of the Department of Budget and Fiscal Planning shall serve in a non-voting, ex-officio capacity.

In addition, each of the following regions must be represented by at least one member:

a. Baltimore Metropolitan;

b. Eastern Shore;

c. Southern Maryland;

d. Western Maryland; and,

e. Washington suburbs.

2. Ethical Considerations

Committee members are prohibited from participating in the preparation, review, and/or decisions on any proposal submitted by the hospital system he or she represents, or by a hospital in direct competition.

3. Terms

The terms of the Committee members shall be two years, provided that the

initial appointments for 5 members shall be for one year.

4. Appointments

All members shall be appointed by the MHA Executive Council and ratified by the MHA Board of Trustees.

B. **Eligibility**

All private, non-governmental hospitals are eligible to apply for funds.

C. **Criteria for Projects**

1. Application Process

Applicants must submit a formal application to the Committee by May 15 of each year. In addition to any other requirements established by the Committee, applicants must:

a. submit an unqualified audited financial report;

b. provide assurances that the project provides access to all citizens regardless of insurance status;

c. obtain any necessary approvals for the proposed project from the HSCRC/HRPC (i.e., CON, rate orders, etc.);

d. provide matching funds, including some demonstrated community financial support (in most cases matching funds should be at least equal to the proposed grant, and should not include real property, in-kind contributions, or funds expended prior to the fiscal year of the grant);

e. submit proposals for projects which have at least a 15-year life; and,

f. submit proposals for projects that are well-developed and ready to be initiated during the ensuing fiscal year.

2. General Policy/Health Promotion Criteria

The Committee shall establish specific criteria for reviewing proposed hospital projects. In general, projects should:

a. improve patient care, particularly access to primary and preventive services and focus on unmet community health and related social needs; and,

b. encourage collaboration and promote the development of provider networks.

In addition, serious consideration should be given to the unique needs of hospitals which are:

a. sole community providers;

b. proposing projects located in underserved areas; or

c. proposing projects of special regional or statewide significance.

3. Financial Capacity Criteria

When considering the merits of a project, the Committee may examine the overall financial capacity and need of the hospital requesting bond funds. In conducting this review, the Committee shall, among other relevant

factors, consider:

a. whether reimbursement/payments for the service rendered by the project will cover expected expenses and the hospital is committed to subsidizing the operating costs of the project;

b. the hospital's level of uncompensated care;

c. the hospital's debt to equity ratio;

d. the hospital's debt service coverage ratio; and,

e. the hospital's Medicaid disproportionate share.

4. Exclusions

Hospital projects that will not be considered for funding under any circumstances include proposals for:

a. construction of new hospitals;

b. projects which result in a net increase in inpatient beds;

c. purchase of major medical equipment,

d. construction or renovation of parking facilities or other non-patient care-related facilities, or

e. retroactive grants.

In addition, any projects that the Governor determines to fund directly in the Capital Improvement Program shall be excluded from this program.

5. Matching Funds

As indicated above, most grants should be supported by cash matching funds in an amount at least equal to the amount of the grant. In some circumstances, this requirement may prevent a project from moving forward. If a project meets a critical and urgent need to serve a low-income population, and the requesting hospital is financially unable to provide an equal cash match, then the Committee may recommend a more liberal matching fund requirement.

D. Recommendations

MHA will forward its recommendations to DBFP by September 1 of each year. (For FY 1995, MHA will forward its recommendations by December 1.)

Annual Level of Funding

Ideally, a funding level would be determined by creating an inventory of capital needs, and then developing a schedule to meet those needs over a period of years.

Unfortunately, the development of such an inventory of needed hospital projects is not practical. To provide guidance as to the appropriate level of funding, the workgroup turned to other factors.

The workgroup recommends that the level of funding for the projects should be up to $5 million a year, or less if fewer projects are warranted. That amount reflects the level of hospital project funding in recent history. In addition, $5 million is close to the amount programmed for MICUA projects.

The workgroup recognizes the difficulty of providing this amount of dollars from the state's Capital Improvement Program for projects previously funded from the annual allocation for legislative initiatives, given competing demands from other high-priority areas such as corrections, public school construction, and higher education. The workgroup considered phasing this funding level in over a period of years. However, given the pace of technological advancement, and the average age of hospital facilities in Maryland, the workgroup felt it would be desirable to provide the full amount immediately.

It is therefore suggested that half of the funding come from the Capital Improvement Program prepared by the Governor and half from the allocation for legislative initiatives.

MULTI-YEAR FUNDING

In the past, the General Assembly has awarded partial funding for certain hospital projects with the tacit understanding that complete funding would be provided in one or

more future years if funding is available.

This practice violates, at least in spirit, the general principle that capital appropriations should completely fund a usable phase of a project. In addition, it places the grantee in a difficult situation where complete funding of a state share is expected, but, not secured with complete certainty.

For these reasons, the workgroup believes that multi-year funding of a state share should be avoided in this process. Grantees may in some cases be able to divide a large project into smaller phases, each of which can be financed separately.

Multi-year funding should be recommended only under extraordinary circumstances, the Governor and General Assembly should be clearly notified of the full funding plan, and the grantee should be made clearly aware that future funding cannot be guaranteed.