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572nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
April 30, 2020

PUBLIC SESSION
12:00 pm

1. **Welcome and Introduction of New Commissioner**

2. **Review of Minutes from Public and Closed Meetings held on April 23, 2020**

3. **Docket Status – Cases Closed**
   2520R – Holy Cross Hospital **2521R – Holy Cross Germantown Hospital**

4. **Docket Status – Cases Open**
   2503R - Johns Hopkins Bayview Medical Center

5. **Confidential Data Request for Johns Hopkins Medicine**

6. **Final Recommendation on COVID-19 Financing Policy**

7. **Presentation on COVID-19 Revenue Modeling and Guidance on Addressing Likely FY 2020 Undercharges**

8. **Capital Funding**

   a. **MHHEFA Bond Authorization Request**

   b. **Draft Recommendation on Capital Funding**

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF APRIL 28, 2020

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2503R	Johns Hopkins Bayview Medical Center	10/15/2019	3/13/2020	3/13/2020	FULL RATE	GS	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

Final Staff Recommendation on the

Request from by Johns Hopkins Medicine to Access HSCRC Confidential Patient Level Data for Inclusion in the Precision Medicine Analytics Platform (PMAP)

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

April 30, 2020

This is a final recommendation for Commission consideration at the April 30, 2020 Public Commission Meeting.

SUMMARY STATEMENT

Johns Hopkins Medicine is requesting to use limited Health Services Cost Review Commission ("HSCRC," or "Commission") inpatient and outpatient confidential data ("the Data") to establish a shared community resource for conducting research on patients who have been tested for COVID-19, leveraging a partition of the existing Precision Medicine Analytics Platform (PMAP) with regional data flowing from CRISP.

OBJECTIVE

In response to the COVID-19 pandemic, the Maryland medical research community has mobilized to establish a rapid approach to COVID-19 data analysis. The project name is Data Analyses for COVID-19 Response (DACOR). The primary aims are: 1) to create a shared research platform, the PMAP, for studying the emerging pandemic; and 2) to understand the clinical progression of COVID-19 within the region and develop risk profiles and predictive models for patients testing positive for the SARS-CoV-2 virus. The shared research platform – hosted by Johns Hopkins University and populated with data from CRISP – will be used to efficiently answer questions from state officials and other stakeholders.

Johns Hopkins Medicine is requesting a limited data set of confidential inpatient and outpatient patient-level data for Calendar Years 2015 to 2020 on a cohort identified by CRISP as having been tested for SARS-CoV-2, the virus that causes the COVID-19 disease, to populate the PMAP. The patients who test negative for SARS-CoV-2 will serve as a control group for the patients who have tested positive within the PMAP.

The investigators are waiting on approval of the MDH IRB to waive the review of subsequent requests to access the PMAP. HSCRC staff will be on the Committee that will review every request for access. The investigators received approval from the Johns Hopkins Medicine Institutional Review Board on April 9, 2020. The Data will not be used to identify individual hospitals or patients. The Data will be retained by Johns Hopkins Medicine for five years (April 30, 2025); at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the internal HSCRC Data Review Board ("the Review Board"). The role of the Review Board is to determine whether the study meets the minimum requirements described below and make recommendations for approval to the Commission at its monthly public meeting. These minimum requirements are as follows:

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Board unanimously agreed to recommend John Hopkins Medicine be given access to the Data. As a final step in the evaluation process, the applicant will be required to file annual progress reports to the Commission, detailing any changes in goals or design of project, data handling procedures, work progress, and unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit to HSCRC a copy of the final report for review prior to public release.

STAFF RECOMMENDATIONS

1. HSCRC staff recommends that the request by Johns Hopkins Medicine for the limited inpatient and outpatient confidential data files for Calendar Year 2015 through 2020 be approved, and that access be limited to identifiable data for subjects meeting the criteria for the research.

2. HSCRC staff recommends that the Commission follows the recommendation of the MDH IRB regarding whether requests to access the PMAP require additional review by the MDH IRB.

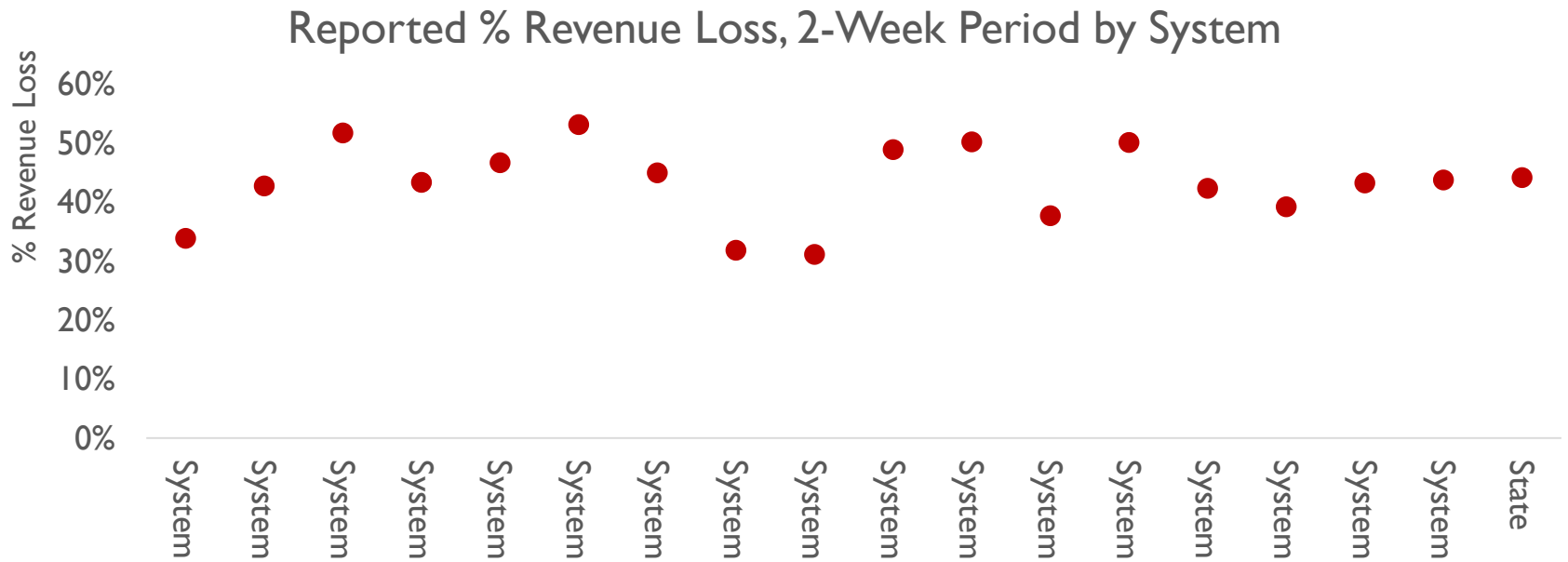
Final Recommendation on COVID Financing Policy

Overview on COVID Funding

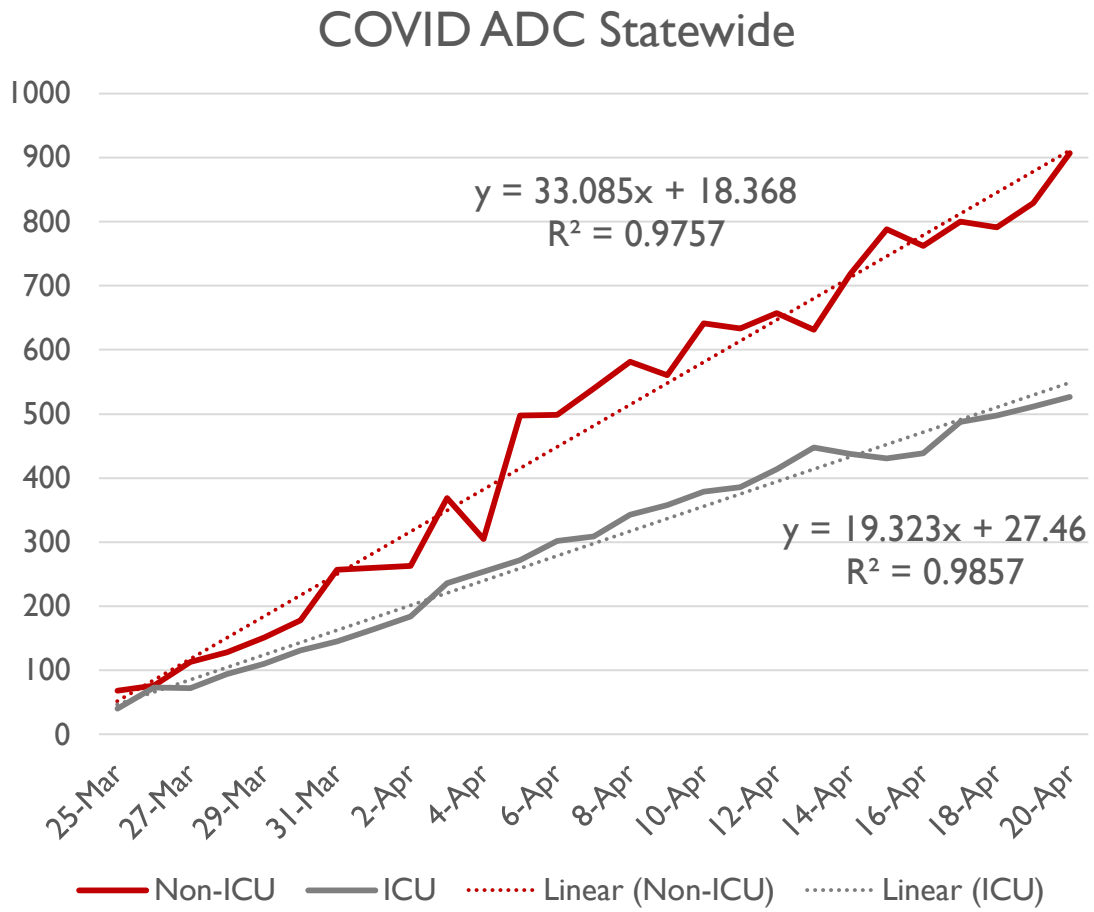
- Staff presented a draft recommendation on financing for COVID cases.
  - The recommendation would make a one-time adjustment to the hospital's GBR if the hospital's charges exceeded their GBR because of COVID.
  - Both CareFirst and MHA commented on the policy and agreed with the recommendation.
  - CareFirst recommended clarifying purpose of rate supporting for COVID cases. Staff believe that the rate support for COVID is designed to account for additional cases that were not included in the base GBR. Staff will retrospectively analyze the variable costs for COVID cases retrospectively.
- Based on current trends, Staff expect that the undercharge for non-COVID volume will exceed charges for COVID cases.
  - Therefore, staff does not expect the COVID Financing Policy to result in significant new spending.
  - However, the number of COVID cases is likely to vary by hospital.
  - This policy will provide certainty to hospitals and allow them to plan an effective response to the COVID crisis.

Reported Revenue Loss Rates – 3/23 to 4/5

- Actual two-week revenue loss estimated by comparing reported revenues for the period to average of March/April weekly revenue last year. COVID revenue was immaterial during the two-week period (no surge)
- Revenue loss of 44% average state wide based on these estimates. Equates to $2.06 B gross revenue loss, $1.85 B net of corridor increases
- Amounts reflect a 2-week snap shot, with no offsetting surge or relaxation of stay-at-home guidance. MHA projections showed lower losses.

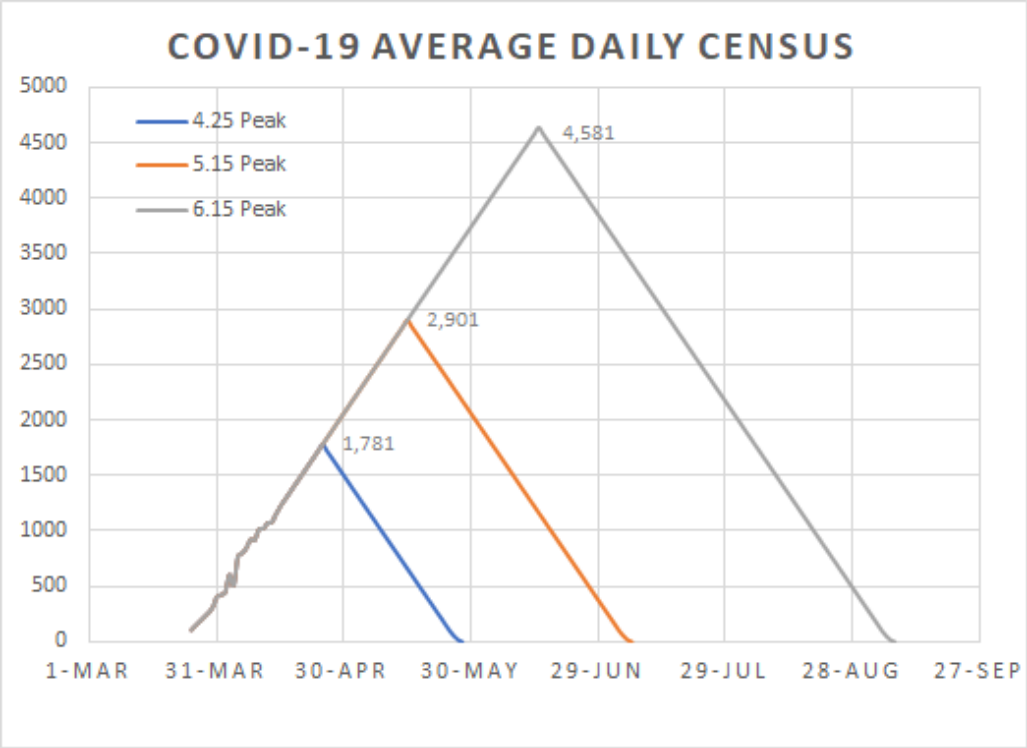


Statewide COVID Census by Day to 4/20/20



- Growth in COVID census has been linear and fairly steady both in the ICU and standard beds
- HSCRC modeling assumed a 35/day increase in non-ICU census and a 21/day increase in ICU census (i.e 56 patient day increment each day).
- Current trends run slightly lower as model was built on slightly older data

Modeling Evaluated 3 Peak Dates – 4/25, 5/15 & 6/15



Each model assumed continuing linear increase through peak date and then the same rate of decline.

Focus is on approximate monthly revenue rather than specific daily estimates.

- Calculated by hospital and statewide charges by applying average charges per day to patient day counts (using MSG and ICU rates).
- Under 6/15 peak monthly COVID charges would be $518 M:
  - April: $77 M
  - May: $185 M
  - June: $256 M

Recommendations on COVID Financing

- Staff recommends that the hospital's FY20 or FY21 GBR be increased if the charges for COVID cases would otherwise cause the hospital to exceed its GBR.
- Specifically, the FY2020 and FY2021 GBR will be equal to Non-COVID GBR plus COVID funding, where:
  - Non-COVID GBR = FY2020 or FY2021 Original GBR
  - COVID Funding = The greater of:
    - $0
    - COVID Standardized Charges – (GBR – Non-COVID Standardized Charges)

Final Recommendation on COVID Surge Funding

April 30, 2020

Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, Maryland 21215

(410) 764-2605

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This document contains the final recommendation for funding additional volume that occurs because of the COVID crisis.

Recommendations

To ensure that hospitals have sufficient revenue to address a possible surge in COVID cases, the HSCRC staff recommends:

- Modifying the hospitals' FY2020 and FY2021 global budget revenue (GBR) to include additional revenue if COVID cases cause the hospital to exceed its GBR;
- Adding any amounts related to COVID cases that exceed the hospital's original GBR as a one-time adjustment to the GBR.

Background

The COVID crisis has caused disruption throughout the hospital and healthcare industries. Hospital volumes have fallen significantly due to the cancelation of elective surgeries and the effects of social-distancing measures. Meanwhile, hospitals have begun to prepare for a potential surge in COVID cases that may result in a corresponding surge in hospitalizations.

Maryland's global budget system is a source of stability during this time. In other states, the dissipation of hospital volumes results in a reduction in hospital revenues at the same time that hospitals are incurring significant costs to prepare for COVID. The GBR system guarantees hospitals a greater degree of financial stability during the dissipation of volumes. The GBR is spread out over time and, therefore, income can be recaptured over a longer time horizon. The HSCRC is also monitoring hospital cash flows. Through other policies, such as expanding rate corridors (i.e. increasing charging capacity), the Commission can better ensure sufficient interim liquidity.

In normal times, the GBR is a revenue cap that disincentivizes hospitals from growing unnecessary volumes and limits revenues to population-related utilization growth. COVID cases are not preventable or avoidable and the FY2020 GBR did not include additional volumes for a pandemic such as COVID. If a large surge in COVID cases occurs, hospitals may find themselves with insufficient revenue in their original GBR.

This recommendation is designed to provide additional funding to hospitals that experience a surge in COVID cases. It is possible that the surge in COVID volume does not occur, in which case the HSCRC expects that the existing GBR will be sufficient to stabilize hospitals during the trough in volume caused by the cancelation of elective surgeries and other measures.

Calculation of the GBR Add-on for COVID

Staff recommends that the FY2020 and FY2021 Global Budget Revenues (GBR) be modified to include additional funding for the treatment of COVID cases, if the volume of those COVID cases would cause the hospital to exceed its original GBR. Specifically, the FY2020 and FY2021 GBR will be equal to Non-COVID GBR plus COVID funding, where:

1. Non-COVID GBR = FY2020 or FY2021 Original GBR
2. COVID Funding = The greater of:
   A) $0
   B) COVID Standardized Charges – (GBR – Non-COVID Standardized Charges)

The COVID and non-COVID standardized charges will be assessed by counting the rate center units for cases with a COVID ICD-10 code and all other ICD-10 codes, respectively. The rate center units will then be multiplied by the relevant rates included on the hospitals' most recent rate order. Hospitals whose

volumes have increased would normally reduce charges to ensure they do not overcharge the GBR. Assessing the additional COVID revenues using the standardized rate on the rate order means that hospitals will not have to reduce charges as volumes rise due to the COVID surge.

The second part of this formula allows hospitals to pass through the additional charges related to COVID. The table below shows an example for a hospital with a GBR of $360 million, where $60 million of non-COVID volume has dissipated. In the first example, the hospital charges $80 million for COVID units (assessed at the standardized charges), which exceeds the revenue associated with dissipated volume ($60 million, again assessed at standardized charges) and thus the hospital receives a net COVID funding of $20 million. In the second example, the hospital charges only $20 million for COVID and the dissipated volume covers the additional COVID volume in its entirety. In this case, while the hospital receives no additional revenue, no revenue is removed from the hospital GBR either. According to the calculation formula, the hospital receives the greater of $0 or COVID Volume – (GBR – Non-COVID Volumes).

Table 1: Examples of Additional COVID Funding

	GBR	Non-COVID $	COVID $	Additional GBR Funding
Example 1	$360m	$300m	$80m	$80m – ($360m - $300m) = $20m
Example 2	$360m	$300m	$20m	$20m – ($360m - $300m) = – $40m[1]

[1] In this case, no revenue is subtracted from the GBR because the formula guarantees them COVID funding equal to the greater of $0 and the calculation above.

Timing and Implementation

This policy will be in effect for the duration of the COVID crisis, which began in March 2020 and will extend until the end of the State of Emergency, the resumption of elective surgeries, and/or a determination by the HSCRC. The HSCRC will publish a notification to the industry when the policy has expired. . The GBR will be prorated based on the duration of the fiscal year during which the COVID crisis was in effect. Prorated shares will be based on the share of the FY2019 GBR that was billed during the months in which the COVID crisis occurs. Prorating the GBR based on prior year charges is necessary to adjust for seasonal patterns in hospital utilization.

For example, if the COVID crisis extends from March to June of 2020, then the HSCRC will calculate the share of the hospitals' FY2019 charges that occurred between March and June of 2019 and apply that share to the hospitals' FY2020 annual GBR. The calculation described in the previous section will then proceed using the COVID and non-COVID volume that occur during the COVID crisis and the prorated GBR.

The additional COVID revenue will be assessed separately for FY2020 and FY2021, and the additional COVID revenues will be added to each hospital's annual GBR before calculating the annual GBR overcharge penalties. A hospital should not exceed its GBR, inclusive of the additional COVID revenues, and penalties will be assessed if the hospital exceeds the GBR plus allowed COVID Funding plus 0.5 percent. The table below shows the calculation for a hypothetical hospital.

Table 2: GBR Compliance Calculation

	Calculation	FY2020	FY2021
Original GBR	A	$360m	$384m
COVID Months	B	4	2
Prorated GBR	C = A x B/12	$120m	$64m
Non-COVID Volume	D	$60m	$32m
COVID Volume	E	$80m	$40m
COVID Financing	F = E - (C - D)	$20m	$8m
GBR Compliance	G = A + F	$380m	$392m

Additional Adjustments

The HSCRC will add additional revenue for the COVID cases prior to assessing the annual GBR compliance. To prevent double-payment to hospitals, that additional revenue may reduce the FY2020 undercharge that hospitals carry over into FY21, and may be reduced by emergency grant funds. The HSCRC will make those adjustments prior to assessing the GBR compliance. The adjustments may be applied to either FY2020 or FY2021 depending on when the assessments are made.

Stakeholder Comments

Staff received comment letters from CareFirst and the Maryland Hospital Association. Both organizations supported the COVID Financing Policy to add additional revenues to the hospital's GBR in the event that the hospital's charges exceed their GBR because of COVID. Both organizations also supported using standardized charges instead of ECMADs or alternative calculations.

CareFirst also recommended that Staff develop a process to ensure that funding streams are not duplicated and have discretion with respect to when the COVID crisis has ended. Staff agree that an orderly process would be beneficial. However, given the speed at which the federal government has passed legislation to address the COVID crisis, deduplicating funding streams will necessarily occur retrospectively and staff believe that the same discretion needed to determine the end of the crisis period is also needed to assess the availability of multiple funding streams. Staff intend to subtract any federal relief funds that are oriented for COVID care and treatment from the additional COVID funding in FY20 or FY21. Staff will identify the funds to be netted against undercharge prior to the informing hospitals of the additional COVID funding that will be added to the hospital's GBR.

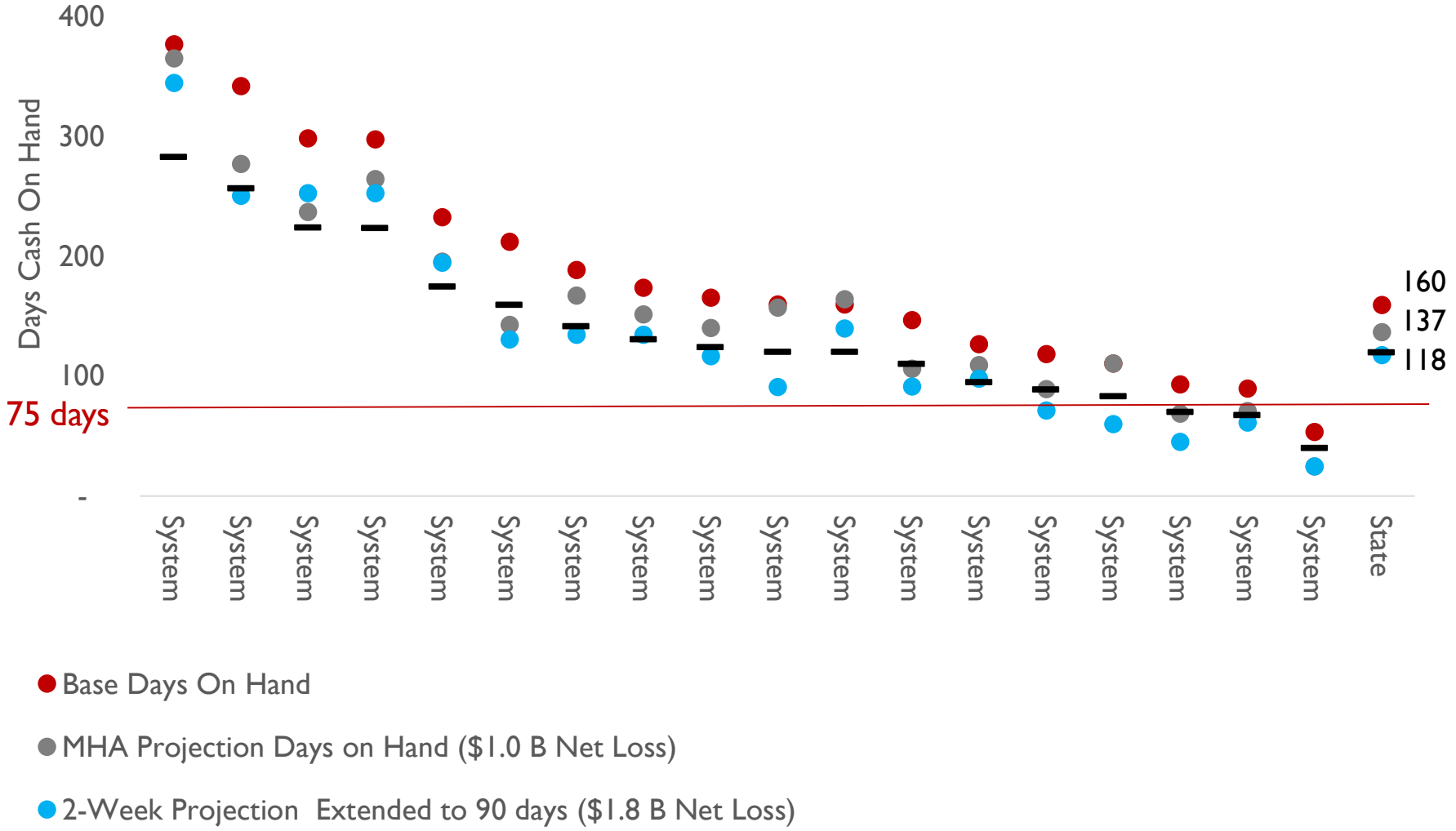
CareFirst also recommended that staff should clearly state the purpose of rate funding on COVID cases and develop a position on the variability of costs for COVID cases. The purpose of the COVID funding policy is to ensure that hospitals have sufficient revenues to treat COVID cases outside of the GBR's fixed revenue cap. Historically, the HSCRC has considered hospitals costs to be 50 percent fixed and 50 percent variable. Marginal volume growth has been funded at 50 percent of the average cost to reflect the variable nature of volume growth. COVID cases are unlikely to have the same cost profile due to both the clinical needs of COVID patients and also the prevailing economic conditions. Assessing the variability of costs prospectively is difficult. Therefore, staff will analyze the cost of COVID cases throughout FY21. This cost assessment will study whether the rates included in the hospitals rate order reflect the actual costs and also the variability of those costs. In the interim, HSCRC believe it is prudent to consider COVID cases to be 100 percent variable given the uniqueness of the circumstances.

Guidance on Addressing Likely FY20 Undercharges

90-day Projected Impact on Cash, Assumptions

- Translated revenue losses into impact on days-cash-on-hand – three scenarios on next slide:
  - Pre-COVID
  - With hospitals' 90-day loss projections shared with HSCRC in MHA survey
  - With 2-week losses extended over 90-day window
- Cash and Investments balance:
  - Includes all cash and investments liquid within 1-year
  - Aggregated individual hospitals to a system level as reported in MHA survey
- Projections scenarios also include the following:
  - $400 M investment loss estimate from MHA survey
  - $90 M of estimate COVID build-up costs from MHA survey
  - $330 M of Federal funds from initial tranche of CARES act, but no borrowing against the Medicare loan program.

Days Cash on Hand – Projected 90 Days
(Hospital Level – Specific Evaluation would include System Resources)



Rate Corridor Policies to Address Cash Flow

- Most hospitals have sufficient liquidity through June 30
  - Only 5 systems are projected to have less than 75 days of cash on hand by the end of the fiscal year.
  - Staff will monitor cash-flow analysis and update the Commissioners on which systems have met the cash on hand trigger.
- For hospitals with less than 75 days cash on hand, HSCRC could expand rate corridors, if necessary, to recoup the undercharge.
  - A rate corridor increase could be granted if the dissipation of volumes continues in FY2021 and hospitals cannot charge the FY2020 undercharge within the existing rate corridors.
  - Federal funds and COVID surge revenues will be netted against the undercharge.
- For hospitals with more than 75 days of cash on hand, no additional rate corridor relief will be granted.
  - A 10% rate corridor increase will be sufficient to recover an undercharge of up to $1.8 billion.
  - Staff's worst-case estimate of the FY20 undercharge is $1.8 billion, assuming no surge in COVID cases, no new federal grant money, and a 40% reduction in volume persists throughout Q4.

Next steps

- Staff will monitor hospital's cash positions and report to the Commission on which hospitals meet the cash on hand trigger
  - Staff will work with MHA and the industry to collect cash and charges data on an ongoing basis.
  - Cash on hand projections will be updated on an ongoing basis.
- Feedback from the industry at the Payment Models Workgroup
  - Staff will solicit comment on the cash on hand trigger and rate corridor polices at a Payment Models Workgroup meeting.
  - Staff will also explore potential rate realignment between inpatient and outpatient rate centers to address the rate orders and units.

COVID-19 Capital Funding & Existing Capital Methodology

Executive Summary

- The State of Maryland has projected that COVID-19 cases could require up to 6,000 additional, temporary hospital beds within the next 3 months.
  - To date, over 3,700 beds at an approximate cost of $70 million have been approved through the Emergency Certificate of Need (Emergency CON) process, led by the Maryland Health Care Commission (MHCC).
  - The State does not anticipate a significant increase in new Emergency CONs

- In line with the HSCRC role in determining which costs should be borne by payers, staff is proposing to issue bonds through the Maryland Health and Higher Educational Facilities Authority (MHHEFA) in order to amortize over several years the cost of building surge capacity in response to COVID-19.
  - Bonds will cover 100% principal and interest in line with the Secretary of Health's letter to Hospital CEOs on March 18, 2020
  - The State expects that a bond issuance will take 3-4 months to complete.
  - In order to bring Emergency CON capacity online now, the State will work with hospitals to utilize their existing credit facilities and then refinance using MHHEFA bonds.
  - HSCRC will repay the MHHEFA bonds through a statewide assessment on hospitals that will be borne by payers.

- Staff seeks authorization to issue $100 million in bonds
  - Potentially increase issuance to $300 million should hospitals incur additional COVID related capital costs
  - Program is contingent on Governor's legal authority to create the program

- In the event a hospital seeks to make MHHEFA funded beds permanent, staff recommend using the existing capital methodology to determine ongoing rate support

Reasons to Fund Temporary Hospital Capacity Through MHHEFA Bonds

- Borrowing costs are very low, estimated to be between 1-2% interest
  - Because of the relatively low amount, funding will be secured through banks so early repayment will not be penalized
- MHHEFA funding provides a greater degree of certainty than federal revenue, as rules for federal relief dollars are changing rapidly
  - Bond revenue can be pegged to exact amount required for temporary capital construction costs
- MHHEFA revenue is accessed relatively quickly, especially if hospitals use existing credit facilities and then refinance with MHHEFA revenue
- Repayment of bonds can be spread out over multiple years at a low borrowing cost, which allows federal relief dollars to be directed to expenses that are not as easily amortized, e.g. cost premiums associated with PPE and staffing

Remaining Concern of Temporary Hospital Capacity Funded through MHHEFA Bonds

- The HSCRC has developed a program to access bond revenue from MHHEFA in order to create temporary, physical hospital capacity for beds requested through the COVID-19 Emergency Certificate of Need (CON) process
  - Bonds will be repaid through a statewide assessment that will cover 100% of principal and interest
  - Assessment will be borne by payers until the bond's maturity
  - Given low borrowing costs, this policy makes good sense, especially while hospital revenues are down because of volume dissipation due to COVID-19 response
- Because the assessments will cover 100% principal and interest, this policy is more generous than the capital financing policy that caps rate support at 70% interest, 100% depreciation
  - As long as capacity funded from MHHEFA bonds does not create permanent beds, there is no inequity; if beds are permanent, there is inequity.
  - Therefore, staff recommends, requiring a) all Emergency CONs to be resubmitted as CONs should a hospital seek to make beds permanent AND b) funding for these beds to be determined by the capital funding methodology
    - Assessments will continue as is to assure bond holders that the bonds will be repaid
    - The difference between the assessment and the amount determined by the capital funding methodology will result in a reduction in revenue to the hospital's revenue base until the bond is fully repaid.

Authorization Request and Draft Recommendations

- Authorization Request
  - **Staff requests authorization from the Commissioners to issue $100 million in bonds through MHHEFA that will be repaid through a hospital assessment.**
  - **Staff also requests authorization to scale the issuance up to $300 million should additional capital costs be incurred during the COVID-19 pandemic.**
  - **The creation of the program is contingent upon the Governor's legal authority.**

- Draft Recommendation
  - **If a hospital seeks to make beds permanent that were approved through the Emergency Certificate of Need process, a hospital will:**
    - **Submit another Certificate of Need to Maryland Health Care Commission that will be subject to feasibility analyses (population demand and financial feasibility)**
    - **Receive funding equivalent to the amount determined by the existing capital funding policy, which will result in a net reduction to a hospital's revenue equal to the difference between the funding provided through MHHEFA bonds and the existing capital methodology**

Authorization Request for Maryland Health and Higher Educational Facilities Authority Bond Program and Draft Recommendation on Capital Policy Implications

April 30, 2020

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document contains both request for the authorization of the Maryland Health and Higher Educational Facilities Authority Bond Program and staff draft recommendations on the implications of that program on funding through the HSCRC Capital Policy. Comment letters on the draft recommendations should be sent to allani.pack@maryland.gov by May 14, 2020.

Table of Contents

Executive Summary

The State of Maryland has projected that COVID-19 cases could require up to 6,000 additional hospital beds within the next 3 months. To date, over 3,700 beds at an approximate cost of $70 million have been approved through the Emergency Certificate of Need (Emergency CON) process, led by the Maryland Health Care Commission (MHCC). The role of the Health Services Cost Review Commission (HSCRC) includes determining which capital hospital costs, if any, should be borne by payers as a public responsibility rather than by the individual hospital. This staff recommendation addresses the situation where a hospital seeks to convert temporary COVID-related capacity achieved through the Emergency CON process into permanent capacity.

In response to the COVID-19 pandemic, the Maryland Secretary of Health, in a March 18 letter to Maryland hospital CEOs, stated that "the State will cover all necessary costs for hospitals to…open and operate any medical/surgical beds or intensive care beds that currently are not in use." To accommodate this, the HSCRC is proposing to issue bonds through the Maryland Health and Higher Educational Facilities Authority (MHHEFA) in order to amortize over several years the cost of building surge capacity in response to COVID-19. The State expects that a bond issuance will take 3-4 months to complete. In order to bring Emergency CON capacity online now, the State will work with hospitals to utilize their existing credit facilities and subsequently refinance using MHHEFA bonds after the program is established.

The HSCRC believes the issuance of MHHEFA bonds is necessary to expedite the process of obtaining capital to finance temporary hospital capacity. The HSCRC, the Maryland Department of Health (MDH) and the Governor will guarantee the repayment of the bonds through the HSCRC's rate-setting authority. Repayment will be assured by an assessment placed on all hospitals. The HSCRC also believes that the indemnification of hospitals as described by the Secretary of Health applies only to temporary hospital capacity in response to the COVID-19 crisis. If a hospital elects to make beds permanent after the COVID-19 crisis, staff recommends using the Commission's existing capital financing policy to reduce the availability of funding by offsetting what was provided for purposes of temporary hospital capacity through alternative means.

Capital Bonds Issued through MHHEFA

In order to finance the construction of surge hospital capacity, the State is considering the issuance of bonds through MHHEFA. The State estimates that each surge bed is expected to cost on average $18,000 per bed (range of $2,000 per bed to $750,000 per bed), based on current Emergency Certificate of Need requests. Thus, the State estimates that at this time a $100 million in capital costs could be incurred to address the current crisis. This value increases slightly when expected interest of 1-2% is accounted for.

The repayment of the bonds will be guaranteed by the hospital rate-setting system. The HSCRC is authorized to set rates for hospital services, and once the HSCRC sets the rate for hospital services those rates must be paid by all payers.

Repayment of MHHEFA Bonds

In order to provide funding for the repayment of the bonds, the HSCRC will increase the rates paid to all hospitals based on the applicable principal and interest payments. This mark-up of rates to the hospitals' global budgets will then be paired with an assessment on all hospitals to repay the cost of capital. The assessment, which will be borne exclusively by payers for the COVID-related costs, will be spread out over the duration of the bond across all payers through all hospitals' rates, regardless of whether or not a hospital requested temporary capacity. In effect, the incremental increase in rates will be diminished, as it will be spread across more payers and consumers over a longer period of time.

In order to issue the bonds, the revenue generated by the bond issuance would need to be indemnified by the State in the event that the HSCRC loses the authority to set rates. In order to accomplish this:

- The Governor (and potentially the Board of Public Works) would need to agree to include the bond payments in the proposed budget in the event that HSCRC loses the authority to issue rates; and
- The HSCRC would then support legislation that would allow the Secretary of Health to assess fees necessary to repay the bonds in the event that the HSCRC loses the ability to set rates, similar to the Maryland Bond Program indemnification under the Economic Development Article Section 10-350(f).

The MHHEFA bonds will finance 100 percent principal and interest of the qualifying capital costs.

Existing Capital Financing Policy and Funding of Temporary Hospital Capacity

A potential inequity exists should a hospital, once the COVID-19 crisis abates, elect to make beds permanent that were financed at 100% principal and interest through MHHEFA bond revenue. Specifically, the HSCRC's existing capital financing policy caps rate support at 70% interest and 100% depreciation; typical outlays are below this standard because funding is scaled for capital cost efficiency, integrated efficiency, and excess capacity. Moreover, the HSCRC offers no rate support for capital projects that do not meet the standard of a "major capital project," which staff expects will not be met through the Emergency CON process. Thus, if a hospital elects to make beds permanent that were originally financed through MHHEFA, in the absence of HSCRC action as per this staff recommendation, the hospital would receive a greater level of rate support than they otherwise would receive through the HSCRC capital financing policy.

To ameliorate this potential inequity, staff recommends requiring: (a) all Emergency CONs to be resubmitted as CONs should a hospital seek to make beds permanent; and (b) funding for these beds to be determined by the HSCRC's existing capital funding methodology. Hospital

assessments to repay the MHHEFA bond issuance will continue as is to assure bondholders that the bonds will be repaid. The difference between the assessment and the amount determined by the HSCRC's capital funding methodology will result in a reduction in revenue to the hospital's revenue base.

Authorization Request

Staff believes the issuance of MHHEFA bonds to provide funding for temporary capital facilities is necessary and appropriate during the COVID-19 pandemic, because this revenue has low borrowing costs; it can be quickly accessed and scaled to meet the exact amount required; and the funding frees up additional federal revenues to be used for operating support and the various cost premiums that hospitals are incurring during the crisis, e.g. surging costs for personal protective equipment.

As such, staff requests authorization from the Commissioners to issue $100 million in bonds through MHHEFA that will be repaid through a hospital assessment. Staff also requests authorization to scale the issuance up to $300 million should additional capital costs be incurred during the COVID-19 pandemic.

The staff understands that execution of the MHHEFA Bond Program as described above is contingent on the issuance of an Executive Order by the Governor, which orders the Secretary of the Maryland Department of Health (MDH) to create a program of this nature during the emergency as the MDH Secretary deems appropriate.

Draft Recommendations

If a hospital seeks to make permanent those beds that were approved through the Emergency Certificate of Need process, a hospital will:

1) Submit another non-emergency Certificate of Need application to the Maryland Health Care Commission that will be subject to feasibility analyses (population demand and financial feasibility); and
2) Receive funding equivalent to the amount determined by the existing capital funding policy, which will result in a net reduction to a hospital's revenue equal to the difference between the funding provided through MHHEFA bonds and the existing capital methodology.

The next Commission meeting is Wednesday, May 13, 2020

A public registration link will be posted on the HSCRC website by May 11, 2020.