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JOHNS HOPKINS
MEDICINE

May 5, 2016

Kevin McDonald
Chief, Certificate of Need
4160 Patterson Avenue
Baltimore, Maryland 21215

MAY 05 2016

RE: Suburban Hospital Matter No. 15-15-2368
Review Questions from April 28, 2016

Dear Mr. McDonald:

Enclosed is Suburban Hospital's response to questions posed in your correspondence dated April 28, 2016. Please note that our response is complete except for Question 2, Need to Continue to Maintain Pediatric Beds. Responding to this question will require a significant amount of new work to compile the necessary data and undertake the analysis requested. As stated in your request for information, Suburban is not proposing to establish a pediatric unit, so the standard cited does not apply to this review. Given that we have complied with your request for a response in one week, and we have supplied all the information requested that is germane to the review of this project, we are hopeful that this project can be considered at the Commission meeting May 19th.

Sincerely,

Anne Langley

cc: Margaret Fitzwilliam

Bed Need

1. **Explain how the projected 2022 discharges shown in Exhibit 1F were derived, particularly the MSGA discharges. Specify the projected populations, discharges rates and market shares that were used. Responses to the following questions would be especially helpful:**

   See Attachment Q1, which outlines the methodology used to derive the 2022 discharges shown in Exhibit 1F:

   a) **Specify the population projections used and the source of those projections. If the 2022 population projections were developed using the 2019 projections included in Exhibit 29 and 2024 projections, specify the 2024 projections, their source, and explain how the 2022 projections were derived.**

      Suburban did not rely on specific population projections to project discharges. Instead Suburban relied on projected service area discharges provided by Truven. As described in Exhibit 31 of the CON, Truven's projected discharges for Suburban's service areas reflect population, demographic and use rate changes. The methodology outlined above and in Attachment Q1 shows how 2024 and 2022 projections were calculated.

      PSA, SSA, and TSA population projections for 2014 and 2019 are included in Exhibit 29. Volume projections for the PSA, SSA, and TSA were supplied by Truven for 2014, 2019, and 2024. Using the methods outlined above, Truven growth rates were applied to actual discharge counts for 2014 sourced to HSCRC, DC, and Virginia Hospital datasets. Specific population values for years other than 2014 and 2019 were not reported.

   b) **Specify the discharge rates used in the development of the 2020 through 2022 projections. If different than the discharge rates specified in Exhibit 31, explain how they were derived.**

      As outlined above, Suburban relied on Truven to provide projected discharges for Suburban's service area. Discharge values provided by Truven for 2014, 2019, and 2019 were used to calculate Suburban's growth rates for the two 5 year periods. See Steps 1-6 for development of projected discharges for 2020 through 2022.

      The rates used for Suburban's discharge projections differ from the rates calculated in Exhibit 31. Exhibit 31 was provided as background information comparing different projection methods. Truven's Adjusted Method growth rate was compared to the growth rate generated by simply holding 2014 use rates constant for projected population changes. The bottom of Exhibit 31 shows that the growth rates Suburban applied to calculate discharges, Truven's Adjusted Model, were lower than alternative methods for all discharge categories.

Truven's Adjusted Method of volume projection was utilized because it yielded far more conservative projections, and represented a more realistic scenario due to its consideration for shifting market forces.

c) **Specify the Suburban market share percentages used for each service and population segment (MSGA 15-64 and 65+). If different market share percentages were used for the primary service area and for the secondary service area, specify each.**

Step 3 shows the calculation of Suburban's market share. Suburban did not calculate separate market share percentages for population segments (MSGA 15-64 and 65+). Instead we believe it is more critical to apply a specific market share to distinct service areas and distinct services. The calculation of market share also excluded services that Suburban does not provide such as OB and newborns.

Step 6 shows the allocation of projected total discharges between MSGA, Psych and Peds.

Need to Continue to Maintain Pediatric Beds

2. **The Acute Care chapter includes a standard covering a hospital proposing to add a pediatric unit; it is:**

> **Minimum Average Daily Census for Establishment of a Pediatric Unit.**
> **An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:**
> **(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or**
> **(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.**

Data and projections in the application shows a very low current and projected utilization, as excerpted below.

Suburban Hospital Pediatric utilization						
	Actual		Projected			
	FY2013	FY2014	2015	2016	2017	2018
Discharges	123	113	75	75	75	77
Patient-days	221	205	136	136	138	138
ALOS	1.8	1.81	1.81	1.81	1.84	1.79
Average census	.61	.58	.37	.37	.38	.38

Since Suburban is not proposing to establish a pediatric unit, this standard is not directly applicable, but it does raise the question of why maintaining the unit is necessary and how it is used. Thus please respond to the following:

a) **How many pediatric patients are seen in the ED?**
b) **How many pediatric patients are transferred to another hospital for admission after being seen in the ED?**
c) **What are the diagnoses of admitted pediatric patients and what procedures do they obtain that require hospitalization?**
d) **How is this service staffed? When pediatric patients are admitted, is there dedicated nursing staff assigned to the pediatric patients?**
e) **Explain how it is more efficient to admit and staff an inpatient service that is expected to serve less than 1.5 admissions per week than simply observing pediatric patients as needed and transferring those in need of admission to a hospital with a critical mass of patients? Quantify costs and benefits in this explanation.**

Construction Cost (MVS)

3. **Why did you start with the higher basement A-B base cost, which is described as finished outpatient, when the basement will be occupied primarily by support services (central sterile processing) and electrical and mechanical spaces? No direct patient services are proposed for the area.**

   Just because the basement is to be used for support services does not mean that it will not be finished to standards that are, at the least, comparable to outpatient standards. As shown on the Departmental Cost Differential filing (p. 42 of the CON application), the Central Sterile Supply has a 1.54 cost differential factor that would be usually applied to the Hospital benchmark (not the basement). Despite that, the total Departmental Cost Differential factor for the Basement is only 0.86, so the fact that other areas are predominantly electrical and mechanical space is accounted for in Suburban's MVS comparison. The MVS base costs for hospital basements is too low to begin with. Based on Suburban's consultants' experience, it is, frankly, not possible to construct a hospital basement at either of the two hospital basement benchmarks, which are approximately $200/square foot less than the hospital benchmark of $365.78.

4. **How many elevators will serve the new basement area?**

   The elevators (1 service and 2 patient) will service the basement area of the addition.

5. **Why on page 45 does it indicate that the penthouse is on the 7th floor when the new addition will only have a basement and four floors?**

   That was an error. It should have said that the penthouse is on the 5th floor. (See CON application, Exhibits 1B and 1C). Hence the factor for the Multi-story Multiplier should be 1.01, not 1.035. Suburban has calculated the impact this correction has on the Consolidated Benchmark for the project, which is included in the response to question 7.

6. **How many elevators will serve the mechanical penthouse?**

   There are no elevators servicing the mechanical penthouse.

7. **The calculation of Departmental Differential includes an MVS department classification of Shafts and Exterior Walls that does appear in the MVS space planning guide (Section 87, Page 8). Explain the source and rationale for this classification.**

   This appears to be an error. It should have been labeled "Internal Circulation, Corridors." Please note that the Departmental Cost Differential Factor for those areas is 0.6, which is the factor for "Internal Circulation, Corridors" and is the lowest Departmental Cost Differential factor (aside from "Unassigned Space").

   These corrections have no material impact on how this project compares to the MVS benchmark. After making these corrections, the following is the consolidated benchmark. (For comparison purposes, Suburban has not updated the base costs or the update factors.)

   Consolidated Benchmark provided in the response to Completeness Question 9, on p. 114:

		MVS Benchmark	Sq. Ft.		Total Cost Based on MVS
Standard					
"Tower" Component		$364.44	235,597	$	85,862,129.23
Basement		$184.70	64,432	$	11,900,450.58
Mechanical Penthouse		$173.68	1,046	$	181,665.23
Consolidated	$	**325.32**	301,075	$	97,944,245.03

   Corrected Consolidated Benchmark:

		MVS Benchmark	Sq. Ft.		Total Cost Based on MVS
Standard					
"Tower" Component		$364.44	235,597	$	85,862,129.23
Basement		$184.70	64,432	$	11,900,450.58
Mechanical Penthouse		$188.74	1,046	$	197,421.95
Consolidated	$	**325.37**	301,075	$	97,960,001.75

Thus the benchmark increases by $ 0.05, or 0.015%. This amount is immaterial to the analysis.

Charity Care Policy

8. **We have some concern on the adequacy of this policy. A decision after receipt of a "complete application" does not meet the intent of the standard, which is giving the applicant a rapid response. The procedure seems to explain a two-step process in which probable eligibility is discussed and help to submit a complete application offered. MHCC needs a better understanding of the policy and how it is being administered. We also need copies of the required notices that are referenced in the standard, too.**

   Standard .04A(2) – Charity Care Policy.

   Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

   a) The policy shall provide:

      (i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.
      (ii) Minimum Required Notice of Charity Care Policy.
         1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;
         2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and
         3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

   First, please find Attachment Q8.1 for a more recent version of the Johns Hopkins Health System Financial Assistance Policy, which applies to Suburban Hospital. The policy submitted last year as part of Suburban's CON application had an effective date of 09/15/2010. The policy included here was effective 10/23/2013. While there are minor changes throughout the newer policy, none of them are relevant to this inquiry. The more recent policy is included for the information of the Commission, with apologies for the oversight of submitting the 2010 policy instead of the 2013 policy previously.

   Appendix A of the policy provides a step-by-step guide to administration of the policy. The second item listed in Appendix A (page 8) states:

   > "A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt."

This is precisely consistent with (a)(i) of the standard. Item 9 of Appendix A describes the process for determination of final eligibility:

> "Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted. The Financial Counselor will issue the final eligibility determination."

In practice, a final determination is provided within two days of receipt of a complete application, and often on the same day.

Suburban provided the following description of its practices on page 25 of the CON application:

> "The Financial Assistance Unit provides each applicant a preliminary approval indicating probably eligibility within two business days of receipt of a complete application."

This description is not correct. It conflates the two scenarios and fails to make clear that a determination of probable eligibility is provided within two days of the applicant simply stating family size and income, while a determination of final eligibility is provided no later than 30 days from receipt of a complete application, but usually on the same day or the next day. While the description provided in the original application does not appear compliant, Suburban's policy and current practice are compliant with the standard.

Consistent with (a)(ii), Suburban provides the following notices of its charity care policy:

1. The policy is published annually in the Washington Post. The proof from the most recently published advertisement is included as Attachment Q8.2.

2. Notice of the policy is posted in English and Spanish in the Emergency Department Lobby, inside the Emergency Department, both ED registration bays, the Front Registration Desk, Catheterization Lab, and Financial Counseling Department. See Attachment Q8.3 for a photograph of the notice that is posted in these areas.

3. Notice of the policy and the financial assistance application is given to every self-pay patient with instructions on how to apply and contact information. The same information is provided to all other patients upon request. See Attachment Q8.4 for a copy of the notice, in English and Spanish.

Efficiency

9. **This standard reads as inserted below:**

> **(11) Efficiency.**
> **A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:**
>
> **(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and**
>
> **(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or**
>
> **(c) Demonstrate why improvements in operational efficiency cannot be achieved.**

Suburban's response did not include any projected measures of these expected improved efficiencies, thus Suburban did not demonstrate that the project will improve operating efficiency. Describing the improved spatial relationship between departments does not demonstrate that the project will improve operating efficiency. Suburban needs to provide quantitative analysis, and should be able to show that that it will need fewer staff per unit of service. Please provide some metrics of how Suburban's *expected staffing/unit of output* is expected to be affected by the project.

By almost every measure, Suburban will be more efficient in 2022 than it was in 2015, the year in which the projections were developed.

Occupancy

As Table F (CON Application, Exhibit 1), Statistical Projections - Entire Facility shows, the percent occupancy in 2022 is projected to be higher than in any of the previous years. That is also true for the individual services MSGA and Psychiatric. A higher occupancy on nursing units naturally increases the efficiency of the unit. Each nursing unit has fixed staff including nurse manager, assist nurse manager, educator, social worker resources and unit secretary. None of these positions flex up to accommodate a higher census/ occupancy.

FTEs

Measuring efficiency as the number of units per FTE in the hospital's core services, total FTEs in 2022 show a higher efficiency by 3.4% than in 2015. The total number of hospital

FTEs in the table below were taken from Table L. Work Force Information (CON Application, Exhibit 1L), while the volumes were taken from Table F. Statistical Projections - Entire Facility (CON Application, Exhibit 1F).

	2015	2022
Inpatient Days	59,624	64,261
Observation Days	3,900	4,709
ED Visits	34,858	38,227
Outpatient Surgery Visits	6,593	6,853
Total	104,975	114,050
Total Hospital FTEs	1,400	1,471
Units/FTE	74.96	77.54

The OR also shows greater efficiency. Projected OR cases per OR FTE is projected to increase by 6.8% in 2022 compared to 2015. The total number of OR FTEs in the table below were taken from Table L. Work Force Information (CON Application, Exhibit 1L), while the volumes were taken from Table 4 - Calculation of FY22 Need for General Purpose Mixed Use Operating Rooms (CON Application, page 79). (Note: these volumes do not include OHS cases.)

	2015	2022
Total Cases	8,338	8,906
OR FTES	142.5	142.5
Cases/FTE	58.5	62.5

Affirmations attached.

Step 1: *Using Suburban Hospital's PSA definition, use Truven to quantify discharges by year and category. Subtract non-Suburban services in order to calculate the PSA growth rate for the 5 and 10 year intervals for "Non-Psych" and "Psych" (color coded).*

Primary Service Area (Source: Truven)

	Discharges		
	2014	**2019**	**2024**
PSA Total	47,999	48,070	49,839
OB deliveries	6,183	5,064	4,426
Neonatology	2,343	1,988	1,656
Newborns	3,036	2,628	2,223
OB no delivery	505	456	434
Psych	2,220	2,505	2,775
Alcohol & Drug Abuse	501	539	582
PSA NET (PSA Total - all other categories)	**33,211**	**34,890**	**37,743**

		2014-2019	2019-2024	2014-2024
PSA NET % growth (without Psych + Alcohol & Drug Abuse)		5.06%	8.18%	13.65%
Psych + Alcohol & Drug Abuse discharges	2,721	3,044	3,357	
Psych + Alcohol & Drug Abuse % growth		11.87%	10.28%	23.37%

Step 2: *Using Suburban Hospital's SSA definition, use Truven to quantify discharges by year and category. Subtract non-Suburban services in order to calculate the SSA growth rate for the 5 and 10 year intervals for "Non-Psych" and "Psych" (color coded).*

Secondary Service Area (Source: Truven)

	Discharges		
	2014	**2019**	**2024**
SSA Total	110,280	110,060	114,510
OB deliveries	13,708	10,850	9,081
Neonatology	4,935	4,262	3,588
Newborns	6,958	6,204	5,355
OB no delivery	1,402	1,217	1,105
Psych	6,063	6,768	7,421
Alcohol & Drug Abuse	1,145	1,234	1,333
SSA NET (SSA Total - all other categories)	**76,069**	**79,525**	**86,627**

		2014-2019	2019-2024	2014-2024
SSA NET % growth (without Psych + Alcohol & Drug Abuse)		4.54%	8.93%	13.88%
Psych + Alcohol & Drug Abuse discharges	7,208	8,002	8,754	
Psych + Alcohol & Drug Abuse % growth		11.02%	9.40%	21.45%
SSA NET % growth with Psych + Alcohol & Drug Abuse; all other non-Suburban services excluded		5.10%	14.53%	

Step 3: *Truven's 2014, 2019, and 2024 projections facilitate the calculation of growth rates over each 5 year period in Steps 1 and 2. The growth rates will be applied to actual 2014 service area discharges sourced to the HSCRC, DC, and Virginia Hospitals.*

Calculate Suburban's categorical market shares (PSA and SSA for both "Non-Psych" and "Psych") by using the Service Area discharges and Suburban Hospital's discharges for FY2014, obtained via HSCRC, DC, and Virginia Hospitals datasets.

Suburban Hospital I/P Discharge Projections	Actual 2014 Discharges			
	Non-Psych		Psych	
	PSA	SSA	PSA	SSA
Service Area Discharges Net of Newborns & Women's Health/ Pregnancy and Psych	27,862	63,764	2,273	5,348
Suburban Discharges Net of Newborns & Women's Health/ Pregnancy and Psych	7,170	2,768	831	465
Suburban's Calculated Market Share	25.7%	4.3%	36.6%	8.69%

Step 4: *Apply the growth rates calculated in Step 1 & Step 2 to the Service Area Discharges listed in Step 3. Holding Suburban's Calculated Market Shares constant, calculate Suburban's Projected Discharges by summing the 4 categories, then dividing by 85% to account for volumes derived from outside of Suburban's Total Service Area.*

	Non-Psych		Psych	
	PSA	SSA	PSA	SSA
2014-2019 Truven growth %	5.06%	4.54%	11.87%	11.02%
2014-2024 Truven growth %	13.65%	13.98%	23.37%	21.45%
Projected 2019 Service Area Discharges	29,271	66,661	2,543	5,937
Projected 2019 Suburban Market Share	25.7%	4.3%	36.6%	8.7%
Projected 2019 Suburban Discharges	**7,532**	**2,894**	**930**	**516**
Projected 2024 Service Area Discharges	31,664	72,614	2,804	6,495
Projected 2024 Suburban Market Share	25.7%	4.3%	36.6%	8.7%
Projected 2024 Suburban Discharges	**8,148**	**3,152**	**1,025**	**565**

	TSA	TSA / 85%
Projected 2019 Discharges	**11,872**	**13,967**
Projected 2024 Discharges	**12,891**	**15,165**

)ject discharges for Suburban Hospital using available information, as well as values calculated in Step 4, and describe source:

14 = actual hospital discharges
15 = annualized hospital discharges
16 = budgeted hospital discharges, ncluding adjustment for unusually high FY15 influenza discharges
19 = value calculated in Step 4
17-2018 = straight-line growth from 2016 budged to 2019 calculated value
24 = value calculated in Step 4
20-2023 = straight-line growth from 2019 calculated value to 2024 calculated value

te: 2023 & 2024 omitted from Table F

Suburban Hospital Projected Discharges

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
:al Suburban Discharges	**13,196**	**13,635**	**13,640**	**13,749**	**13,858**	**13,967**	**14,207**	**14,446**	**14,686**	**14,926**	**15,165**

)ject TSA Psych discharges only using 2014 actual values in from Step 3 and calculated 2019 and 2024 values from Step 4:

14 = actual in Step 3
19 = value calculated in Step 4
24 = value calculated in Step 4
15-2018 = straight-line growth from 2014 to 2019
20-2023 = straight-line growth from 2020 to 2023

)ort actual 2014 Suburban Psych Discharges and gross up TSA Psych Discharges by 5% for 2015-2024 (instead of 15%, for a more realistic calculation, given Psych is a less regional service), to)vert TSA Psych Discharges to Suburban Psych Discharges to account for Psych patients from outside Suburban's TSA.

)ort actual 2014 Suburban Peds Discharges, annualized 2015 discharges, and grow 2016-2024 Suburban Peds Discharges proportional to Total Suburban Discharges.

)ort Suburban MSGA Discharges by subtracting Suburban Psych Discharges and Suburban Peds Discharges from Total Suburban Discharges.

te: 2023 & 2024 omitted from Table F

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
)urban TSA Psych Discharges	1,296	1,326	1,356	1,386	1,416	1,446	1,475	1,504	1,532	1,561	1,590
)urban Psych Discharges	1,484	1,396	1,427	1,459	1,490	1,522	1,552	1,583	1,613	1,643	1,674
)urban Peds Discharges	113	75	75	76	76	77	78	79	81	82	83
)urban MSGA Discharges	**11,599**	**12,164**	**12,138**	**12,215**	**12,291**	**12,368**	**12,576**	**12,784**	**12,992**	**13,200**	**13,408**

JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	**The Johns Hopkins Health System Policy & Procedure**	*Policy Number*	FIN034H
		Effective Date	10-23-13
	Subject	*Page*	1 of 21
	FINANCIAL ASSISTANCE	*Supersedes*	05-15-13

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: Howard County General Hospital (HCGH) and Suburban Hospital (SH).

Purpose

JHHS is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, also will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted so long as other requirements are met.

Definitions

Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the JHHS hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay(opting out of insurance coverage, or insurance billing)
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If

patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.

Medically Necessary Care	Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for the purposes of this policy does not include elective or cosmetic procedures.
Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.

PROCEDURES

1. An evaluation for Financial Assistance can begin in a number of ways:

   For example:

   - A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.

2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.

3. Designated staff may meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, as defined by Medicaid regulations. To help applicants complete the process, a statement of conditional approval will be provided that will list the paperwork required for a final determination of eligibility.

   b. Applications received will be sent to the JHHS Patient Financial Services Department for review; a written determination of probable eligibility will be issued to the patient.

   c. At HCGH, complete applications with all supporting documentation submitted at the hospital are approved via the appropriate signature authority process. Once approved

and signed off on, the approved applications will be sent to the JHHS Patient Financial Services Department's to mail patient a written determination of eligibility.

4. To determine final eligibility, the following criteria must be met:

   a. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

   b. All insurance benefits must have been exhausted.

5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:

   a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).

   b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).

   c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

   d. A Medical Assistance Notice of Determination (if applicable).

   e. Proof of disability income (if applicable).

   f. Reasonable proof of other declared expenses.

   g. Non-U.S. citizens must complete the Financial Assistance Application (Exhibit A). In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO (HCGH) or Director of PFS and/or CFO (SH) to determine if additional information is necessary.

   h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles for medical costs billed by a JHHS hospital. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines. At HCGH, the Financial Counselor will forward to Director, Revenue Cycle for review and final eligibility based upon JHMI guidelines.

a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments for reconsideration to the CFO (HCGH) or Director PFS and CFO (SH) for final evaluation and decision.

b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will have a final determination made no later than 30 days from the date the application was considered complete. The Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will base their determination of financial need on JHHS guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

8. Services provided to patients registered as Voluntary Self Pay do not qualify for Financial Assistance.

9. A department operating programs under a grant or other outside governing authority (i.e.: Psychiatry Program) may continue to use a government-sponsored application process and associated income scale.

10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient makes a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.

11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patients representative requests an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application (Exhibit A) unless they meet Presumptive Financial Assistance

Eligibility criteria (see Appendix A-1). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

14. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.

15. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25. If hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

16. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.

REFERENCE[1]

JHHS Finance Policies and Procedures Manual
Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Code of Maryland Regulations COMAR 10.37.10.26, et seq
Maryland Code Health General 19-214, et seq
Federal Poverty Guidelines (Updated annually) in Federal Register

[1] NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

RESPONSIBILITIES - HCGH, SH

Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance	Understand current criteria for Assistance qualifications. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form. On the day preliminary application is received, send to Patient Financial Services Department's for determination of probable eligibility. Review preliminary application (Exhibit A), Patient Profile Questionnaire (Exhibit B) and Medical Financial Hardship Application (Exhibit C), if submitted, to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review. Review and ensure completion of final application. Deliver completed final application to appropriate management. Document all transactions in all applicable patient accounts comments. Identify retroactive candidates; initiate final application process.
Management Personnel (Supervisor/Manager/Director)	Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.] Notices will not be sent to Presumptive Eligibility recipients.
Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff	Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

CFO (HCGH, SH)
Director of Revenue Cycle (HCGH)
Director, PFS (SH)

REVIEW CYCLE

Two (2) years

APPROVAL

Sr. VP of Finance/Treasurer & CFO for JHH and JHHS

11-1-2013
Date

APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. Each patient requesting Financial Assistance must complete a JHM/Financial Assistance Application (also known as the Maryland State Uniform Financial Assistance Application) Exhibit A, and Patient Profile Questionnaire, Exhibit B. If patient wishes to be considered for Medical Financial Hardship, patient must submit Medical Financial Hardship Application, Exhibit C.

2. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.

3. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

4. Proof of income must be provided with the final application. Acceptable proofs include:
   (a) Prior-year tax return;
   (b) Current pay stubs;
   (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
   (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
   (e) For non-U.S. citizens, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.

5. Patients will be eligible for Financial Assistance if their maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify. If it is clear that a non-U.S. citizen will not be eligible for Medical Assistance, a Medical Assistance Notice of Determination will not be necessary.

7. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.

8. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.

9. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted. The Financial Counselor will issue the final eligibility determination.

10. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.

11. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application (Exhibit A) will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial Assistance from another affiliate.

12. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

Exceptions
The Vice President, Finance/CFO may make exceptions according to individual circumstances.

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/15

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	$ 23,540	$ 25,894	$ 28,248	$ 30,602	$ 32,956	$ 35,310
2	$ 31,860	$ 35,046	$ 38,232	$ 41,418	$ 44,604	$ 47,790
3	$ 40,180	$ 44,198	$ 48,216	$ 52,234	$ 56,252	$ 60,270
4	$ 48,500	$ 53,350	$ 58,200	$ 63,050	$ 67,900	$ 72,750
5	$ 56,820	$ 62,502	$ 68,184	$ 73,866	$ 79,548	$ 85,230
6	$ 65,140	$ 71,654	$ 78,168	$ 84,682	$ 91,196	$ 97,710
7	$ 73,460	$ 80,806	$ 88,152	$ 95,498	$ 102,844	$ 110,190
8*	$ 81,780	$ 89,958	$ 98,136	$ 106,314	$ 114,492	$ 122,670
**amt for each member	$8,120	$8,932	$9,744	$10,556	$11,368	$12,180
Allow ance to Give:	100%	80%	60%	40%	30%	20%

*200% of Poverty Guidelines
**For family units with more than eight (8) members

EXAMPLE:

Annual Family Income	$54,000
# of Persons in Family	4
Applicable Poverty Income Level	$47,700
Upper Limits of Income for Allowance Range	$57,240 (60% range)

($54,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

Appendix A-1

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- Primary Adult Care Program (PAC) coverage*
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- active enrollees of the Chase Brexton Health Center (See Appendix C) (applicable for HCGH patients)
- active enrollees of the Healthy Howard Program (see Appendix D) (applicable for HCGH patient)
- Participation in Women, Infants and Children Programs (WIC)*
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility *
- Households with children in the free or reduced lunch program*
- Low-income household energy assistance program participation*
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- patients referred to Suburban Hospital by organizations which have partnered with Suburban (See Appendix E)
- Patient is deceased with no known estate
- Health Department moms – For non-emergent outpatient visits not covered by medical assistance
- Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
- Patients returned by SRT as not meeting disability criteria but who meet the financial requirements for Medical Assistance

*These life circumstances are set forth in COMAR 10.37.10.26 A-2. The patient needs to submit proof of enrollment in these programs within 30 days of treatment unless the patient requests an additional 30 days.

APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance. This determination will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:
1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
2.) who meet the income standards for this level of Assistance are met.

For those patients who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines, JHHS shall apply the reduction in charges that is most favorable to the patient.

Medical Financial Hardship is defined as Medical Debt for Medically Necessary treatment incurred by a family over a twelve (12) month period that exceeds 25% of that family's income.

Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Carebilled by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting JHM/Financial Assistance Application, also known as the Maryland State Uniform Financial Assistance Application (Exhibit A), and the Patient Profile Questionnaire (Exhibit B). The patient guarantor must also submit financial documentation of family income for the twelve (12) calendar months preceding the application date and documentation evidencing Medical Debt of at least 25% of family income.

Once a patient is approved for Medical Hardship Financial Assistance, Medical Hardship Financial Assistance coverage shall be effective starting the month of the first qualifying service and the following twelve (12) calendar months. It shall cover those members of the patient's Immediate Family residing in the same household. The patient and the Immediate Family members shall remain eligible for reduced cost Medically Necessary Care when seeking subsequent care at the same hospital for twelve (12) calendar months beginning on the date on which the reduced cost Medically Necessary Care was initially received. Coverage shall not apply to Elective Admissions or Elective or cosmetic procedures However, the patient or the patient's immediate family member residing in the same household must notify the hospital of their eligibility for the reduced cost Medically Necessary Care at registration or admission.

General Conditions for Medical Financial Hardship Assistance Application:

1. Patient's income is under 500% of the Federal Poverty Level.
2. Patient has exhausted all insurance coverage.
3. Patient account balances for patients who chose to register as voluntary self pay shall not counted toward Medical Debt for Medical Financial Hardship Assistance.
4. Patient/guarantor do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.
5. Patient is not eligible for any of the following:
   - Medical Assistance

- Other forms of assistance available through JHM affiliates

6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.

7. The affiliate has the right to request patient to file updated supporting documentation.

8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.

9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Medical Financial Hardship Assistance Application:

- Medical Debt incurred over the twelve (12) months preceding the date of the Financial Hardship Assistance Application at the JHHS treating facility where the application was made.
- Liquid Assets (leaving a residual of $10,000)
- Family Income for the twelve (12) calendar months preceding the date of the Financial Hardship Assistance Application
- Supporting Documentation

Exceptions

The Vice President, Finance/CFO or designee may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.

2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/15

# of Persons in Family	Income Level**		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	**$ 35,310**	$ 47,080	$ 58,850
2	**$ 47,790**	$ 63,720	$ 79,650
3	**$ 60,270**	$ 80,360	$ 100,450
4	**$ 72,750**	$ 97,000	$ 121,250
5	**$ 85,230**	$ 113,640	$ 142,050
6	**$ 97,710**	$ 130,280	$ 162,850
7	**$ 110,190**	$ 146,920	$ 183,650
8*	**$ 122,670**	$ 163,560	$ 204,450
Allowance to Give:	50%	35%	20%

*For family units with more than 8 members, add $12,480 for each additional person at 300% of FPL, $16,640 at 400% at FPL; and $20,800 at 500% of FPL.

APPENDIX C (HCGH only)
FINANCIAL ASSISTANCE FOR CHASE BREXTON PATIENTS

Purpose

Chase Brexton Health Services, Inc. is a non-profit, community based organization that provides a wide range of medical, psychological and social services on a non-discriminatory basis in Baltimore City, Baltimore County, and Howard County. Chase Brexton offers services to everyone regardless of their ability to pay. Chase Brexton cares for those who are uninsured or under-insured, those with Medicare and Medicaid, and those with commercial insurance. Chase Brexton has Case Managers that work with patients to determine eligibility for care at a low minimum fee, and/or appropriate programs and entitlements available to people with limited resources.

This procedure is for Howard County General Hospital registration sites, verification and scheduling and for Patient Financial Services. It outlines the treatment of patients that have qualified for Chase Brexton Health Services. It is the policy of HCGH to accept patients previously screened by Chase Brexton for financial assistance. Patients will not have to apply for assistance but will need to notify HCGH of their participation in this program.

Inpatient/Outpatient cases

All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker for the application process. If medical assistance is received, the claim is billed to Medical Assistance for payment. If the patient is not eligible for medical assistance, the insurance plan of FAR.PENDIN, FARB20, FARN40, FARN50, FARN70 FARN80, and FAR100 is assigned to the case and the claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released. The insurance code assignment is based on the level of charity care the patient has qualified for.

Insurance listed as:	**Charity Care**	**Patient to pay:**
FAR.PENDIN	Pending Verification	
FARB20	20% of charges	80% of charges
FARN40	40% of charges	60% of charges
FARN50	50% of charges	50% of charges
FARN70	70% of charges	30% of charges
FARN80	80% of charges	20% of charges
FAR100	100% of charges	0% of charges

PROCEDURE

1. When a patient presents for services at HCGH and states they are associated with the Chase Brexton health center, the registration staff will enter the insurance code of FAR.PENDIN into Meditech if the patient hasn't been seen within the last 6 months. If the patient is in the system with a service date within the last 6 months and the patient was already identified as a Chase Brexton patient that met a certain level of charity care the registrar can allow the insurance code of (FARB20, FARN40 etc,) to be pulled forward.

2. The Sr. Financial Counselor receives a daily report with all patients registered with a FAR code.

3. The Sr. Financial Counselor will review all patients on the report daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for.

4. The Sr. Financial Counselor is responsible for updating the insurance code to reflect the proper level of charity care and collecting the patient balance (if any).

5. The Sr. Financial Counselor is responsible for entering a form and through date into Meditech that the patient is eligible to receive this level of charity care.

6. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.

APPENDIX D (HCGH only)
FINANCIAL ASSISTANCE FOR HEALTHY HOWARD PATIENTS

Purpose

The Healthy Howard Access Plan is a new program effective January 1, 2009, designed to connect Howard County residents to affordable health care services and help the community overcome barriers to healthy living. The Plan is not insurance, but offers basic medical and preventative care to eligible residents who would otherwise not be able to afford or obtain health insurance.

This procedure is for Howard County General Hospital registration sites, verification and scheduling, and Patient Financial Services. It outlines the treatment of patients that are enrolled in the Healthy Howard Plan.

Inpatient/Outpatient cases

It is the policy of HCGH to accept Healthy Howard plan patients for referred scheduled services, and emergent/urgent services.

It is the responsibility of the patient to provide their Healthy Howard identification card or inform the registration/scheduling staff of Healthy Howard coverage at the time of service or scheduling.

It is the responsibility of the HCGH registration/authorization staff to verify that coverage is still active by checking eligibility via. MCNET (a web based system administered by JHHC).

For Healthy Howard patients utilizing the emergency department, $100 co-pay is due. However; if admitted or placed into observation the co-pay is waived.

The patient should be registered using the insurance code HLTH.HOW.

The HLTH.HOW insurance code has been programmed to automatically write off the charges to the financial assistance code when the final bill is released.

Procedure

1. When a patient presents for services at HCGH and either presents a Healthy Howard insurance card or notifies the registration staff that they are a member of Healthy Howard the registrar should verify eligibility using MCNET to validate the patient is an active enrollee.
2. If active, the Admission Counselor will register the patient with the insurance code HLTH.HOW.
3. If not active, notify the patient of ineligibility and ask if there is other insurance or means to pay. If not, provide the patient with the HCGH financial assistance application.
4. The Sr. Financial Counselor prints a report on a daily basis of all patients registered with HLTH.HOW.
5. The Sr. Financial Counselor will review all patients on the report to validate they are active with Healthy Howard.
6. The Sr. Financial Counselor is responsible to monitor Healthy Howard in-house inpatient admissions to determine if at some point the patient may become eligible for MD Medical Assistance. If so, the Sr. Financial Counselor will meet with the patient to assist in the application process.
7. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be corrected as appropriate.

APPENDIX E (Suburban Hospital only)
FINANCIAL ASSISTANCE FOR MONTGOMERY COUNTY AND LOCALLY BASED PROGRAMS FOR LOW INCOME UNINSURED PATIENTS

Purpose

Suburban Hospital is partnered with several Montgomery County, MD and locally based programs that offer primary care services and/or connection to local specialty and hospital based care. Based on agreements with these partnered programs, Suburban Hospital provides access to inpatient and outpatient care to patients who would not otherwise be able to access or afford medically necessary care.

Policy

Suburban Hospital shall accept charity referrals for medical necessary care from the following providers: Catholic Charities, Mobile Med, Inc., Montgomery County Cancer Crusade, Primary Care Coalition, Project Access, and Proyecto Salud. Care is provided to such patients based on meeting eligibility requirements for one of the aforementioned local programs.
Patients must provide a program generated referral for care as proof of their enrollment in one of the above programs to qualify for presumptive approval for 100% free care. Suburban Hospital shall base acceptance of such referrals on the referring programs' enrollment of patients using their income based eligibility requirements which for these designated programs is at or below a maximum of 250% of the federal poverty guidelines.

Procedure

1. When a patient is scheduled and/or presents for services at SH, the patient must provide a referral form from one of the above programs as proof of enrollment.
2. Once the referral form is received, the Scheduler or Registrar will apply to the account a designated insurance mnemonic for the referring partnered program.
3. If no referral form is received by the patient, the account will be registered as self pay. The patient has 30 days to produce a referral or proof of enrollment in one of the partnered programs. An additional 30 days will be allowed upon request from the patient.
4. A Financial Counselor and/or Registrar will check the real time eligibility or Maryland EVS System to verify enrollment in Maryland Medicaid. If enrolled, Medicaid will prevail and free care presumptive approval will not apply.
5. Each hospital account with a designated insurance mnemonic for one of the partnered programs will be subject to final review for the existence of a program referral prior to application of the program driven charity adjustment. Presumptive approval for 100% free care applies to a single episode of care (account) only.

Exhibit A

Howard County General Hospital
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number ____-____-____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals

	Monthly Amount
Employment	
Retirement/pension benefits	
Social security benefits	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance			Approximate value	
Automobile	Make		Year	Approximate value	
Additional vehicle	Make		Year	Approximate value	
Additional vehicle	Make		Year	Approximate value	
Other property				Approximate value	
			Total		

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit card(s)	
Car insurance	
Health insurance	
Other medical expenses	
Other expenses	
Total	

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #:_____

1. What is the patient's age? _____
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

   Family Size:

   Individual: $2,500.00

   Two people: $3,000.00

   For each additional family member, add $100.00

   (Example: For a family of four, if you have total liquid assets of less than $3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
   If not a Maryland resident, in what state does patient reside? _____
9. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does patient receive Food Stamps? Yes or No
12. Does patient currently have:
    - Medical Assistance Pharmacy Only Yes or No
    - QMB coverage/ SLMB coverage Yes or No
    - PAC coverage Yes or No
13. Is patient employed? Yes or No
    If no, date became unemployed. _____
    Eligible for COBRA health insurance coverage? Yes or No

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #:_____

Date: _____

Family Income for twelve (12) calendar months preceding date of this application: _____

Medical Debt incurred at The Johns Hopkins Hospital (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of service	Amount owed
_____	_____
_____	_____
_____	_____
_____	_____

All documentation submitted becomes part of this application.

All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

_____ Date: _____
Applicant's signature

_____
Relationship to Patient

For Internal Use: Reviewed By:
_____Date:_____

Income: _____ 25% of income=_____

Medical Debt: _____Percentage of Allowance: _____

Reduction: _____

Balance Due: _____

Monthly Payment Amount:_____ Length of Payment Plan:_____month

Washington Post Media

The Washington Post | washingtonpost.com | Express
El Tiempo Latino | washingtonpostmobile

Questions or comments regarding your proof should be directed to your account representative. If you do not know your account representative, please use the appropriate number below.

(202) 334-4710 - Automotive
(202) 334-7029 - Merchandise
(202) 334-5800 - Real Estate
(202) 334-5787 - Business Opportunities
(202) 334-4122 - Paid Death Notices
(202) 334-6200 - Classified Advertising
(202) 334-4100 - Jobs
(202) 334-5725 - Property Management
(202) 334-7007 - Legal Notices

Classified Ad Proof

BP Account # 1010041355

Ad Number 11964618

BP Name SUBURBAN HOSPITAL/PERSONNEL ATTN: JASON WANG

Advertiser # 1010041355

Purchase/Insertion Order # Charity Care Policy

Advertiser Name SUBURBAN HOSPITAL/PERSONNEL ATTN: JASON WANG

Start Date Oct 28, 2015

End Date Oct 28, 2015

Number of Insertions 1

Ad Size 1 CO X 1.133 "

Keyword Suburban Hospital Charity Care Policy S

16 LINES

Price $168.84

Content Component and Description

820

Official Notices

Sales Rep ALIANZAJAVC

Date Ad Proof is Generated Oct 26, 2015

System Message

Special Instructions

Suburban Hospital Charity Care Policy

Suburban Hospital, a member of Johns Hopkins Medicine maintains accessibility to all services regardless of an individual's ability to pay. The hospital policy on charity care is that the hospital will provide necessary emergency medical care to all persons regardless of their ability to pay and will consider for charity care those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/or inability to pay.

Asistencia Financ

Suburban Hospital provee un
idad sin tener en cuenta la
por parte del paciente. Si u
rmacion sobre una solicitud
nciera, contacto con el coor
asistencia financiera a

1-866-323-4615

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

PATIENT BILLING and FINANCIAL ASSISTANCE INFORMATION SHEET

Billing Rights and Obligations

Not all medical costs are covered by insurance. The hospital makes every effort to see that you are billed correctly. It is up to you to provide complete and accurate information about your health insurance coverage when you are brought in to the hospital or visit an outpatient clinic. This will help make sure that your insurance company is billed on time. Some insurance companies require that bills be sent in soon after you receive treatment or they may not pay the bill. Your final bill will reflect the actual cost of care minus any insurance payment received and/or payment made at the time of your visit. All charges not covered by your insurance are your responsibility.

Financial Assistance

If you are unable to pay for medical care, you **may qualify for Free or Reduced-Cost Medically Necessary Care** if you:

- Have no other insurance options
- Have been denied medical assistance or fail to meet all eligibility requirements
- Meet specific financial criteria

If you do not qualify for Medical Assistance or financial assistance, you may be eligible for an extended payment plan for your medical bill.

Call: 866-323-4615

With questions concerning:

- Your hospital bill
- Your rights and obligations with regard to your hospital bill
- Your rights and obligations with regard to reduced-cost medically necessary care due to financial hardship
- How to apply for free and reduced-cost care
- How to apply for Maryland Medical Assistance or other programs that may help pay your medical bills

For information about Maryland Medical Assistance

Contact your local department of Social Services
1-800-332-6347 TTY 1-800-925-4434
Or visit: www.dhr.state.md.us

Physician charges are not included in hospital bills and are billed separately.

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

HOJA INFORMATIVA SOBRE LA FACTURA DE PACIENTES Y LA ASISTENCIA FINANCIERA

Los derechos y obligaciones de la factura

No todos los costos médicos son cubiertos por el seguro. El hospital hace todo lo possible para estar seguro de que usted reciba la factura correcta. Depende de usted proveer la información completa y precisa sobre su cobertura de seguro médico cuando le traen al hospital o cuando visita la clínica ambulatoria. Esto ayudará a asegurar que se manden las facturas a su compañía de seguros a tiempo. Algunas compañias de seguro requieren que se manden las facturas tan pronto como usted recibe el tratamiento, de lo contrario pueden no pagarlas. Su factura final reflejará el verdadero costo de su cuidado, menos cualquier pago que se haya recibido o hecho al momento de su visita. Todo cobro no cubierto por su seguro es responsabilidad suya.

Asistencia financiera

Si usted no puede pagar por su cuidado médico, es possible que califique para cuidado médicamente necesario gratuito o de bajo costo si usted:

- No tiene otras opciones de seguro
- Le ha sido negada la asistencia médica, o no cumple con todos los requisitos de elegibilidad
- Cumple con criterios financieros específicos.

Si usted no califica para la Asistencia Médica o la asistencia financiera, es possible que sea elegible para un sistema de pagos extendidos para sus facturas médicas.

Llame a: 866-323-4615

Con sus preguntas referentes a:

- Su factura del hospital
- Sus derechos y obligaciones en cuanto a su factura del hospital
- Sus derechos y obligaciones de lo que se refiere a la reducción de costo, al cuidado médico necesario debido a dificultades financieras
- Cómo inscribirse para cuidado gratuito o de bajo costo
- Cómo inscribirse para la Asistencia Médica de Maryland u otros programas que le puedan ayudar a pagar sus facturas médicas.

Para más información sobre la Asistencia Médica de Maryland

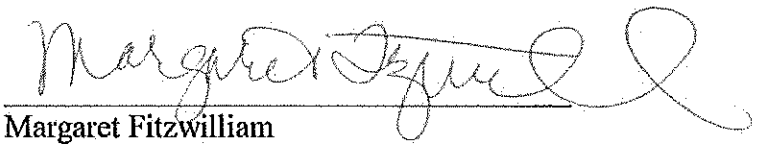
Por favor llame a su departamento local de Servicios Sociales
1-800-332-6347 TTY 1-800-925-4434
O visite al: www.dhr.state.md.us

Los cobros de los médicos no se incluyen en las facturas del hospital, son facturas aparte.

AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



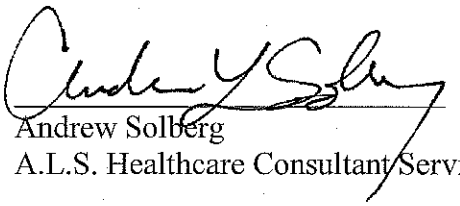
5/5/2016

Margaret Fitzwilliam
Director, Capital Renovation Planning & Space Management
Suburban Hospital, Inc.

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Andrew Solberg
A.L.S. Healthcare Consultant Services

5/3/2016
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Anne Langley
Senior Director, Health Planning and Community Engagement
Healthcare Transformation and Strategic Planning
Johns Hopkins Health System, Inc.

5 May 2016
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Spencer Wildonger
Senior Project Analyst
Health Care Transformation & Strategic Planning
Johns Hopkins Health System

5/5/2016
Date