VENABLE LLP

750 E. PRATT STREET SUITE 900 BALTIMORE, MD 21202
T 410.244.7400 F 410.244.7742 www.Venable.com

Marta D. Harting (410) 244-7542 mdharting@venable.com

April 11, 2019

VIA ELECTRONIC MAIL
AND HAND DELIVERY

Ruby Potter, Administrator
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Development
4160 Patterson Avenue
Baltimore, MD 21215

Re: In the Matter of Johns Hopkins Bayview Medical Center
Docket No. 18-24-2430

Dear Ms. Potter:

Enclosed are six copies of Applicant's Response to Reply Comments of United Workers, Charm City Land Trust and Sanctuary Streets.

Thank you for your attention to this matter.

Sincerely,

Marta D. Harting

Marta D. Harting

MDH:rlh
Enclosures

IN THE MATTER OF	*	BEFORE THE
JOHNS HOPKINS	*	MARYLAND
BAYVIEW MEDICAL CENTER	*	HEALTH CARE
Docket No. 18-24-2430	*	COMMISSION

* * * * * * * * * * * *

APPLICANT'S RESPONSE TO REPLY COMMENTS OF UNITED WORKERS, CHARM CITY LAND TRUST AND SANCTUARY STREETS

The Applicant, Johns Hopkins Bayview Medical Center ("JHBMC"), responds to the Reply Comments filed by United Workers, Charm City Land Trust and Sanctuary Streets (the "Commenters"). JHBMC filed a Motion to Strike the Commenters' Reply Comments on April 3, 2019 on grounds that the filing violates COMAR 10.24.01.08F. If the Commission does not strike the Reply Comments, JHBMC responds to those Reply Comments as set forth herein.

ARGUMENT

1. The Applicant Was Not Required to File A Motion To Exclude The Commenters From This Review.

The Commenters argue that JHBMC is required to file a motion to "exclude" the Commenters from this review under COMAR 10.24.01.10(B). This argument is based on the false premise that the Commenters are already parties to this review, such that the burden is on JHBMC to move to "exclude" them. The Commenters are not interested parties unless and until the Reviewer determines that they have demonstrated that they are "adversely affected" (i.e., could suffer a potentially detrimental impact from the approval of the project in an issue area over which the Commission has jurisdiction) such that the Reviewer determines, in the reviewer's discretion, that the Commenters should

be qualified as interested parties. COMAR 10.24.01.01B(2). There would be no basis for the Applicant to file a motion to exclude the Commenters from this review before the Reviewer has determined that they are entitled to be parties in the first place.

The Comments state the grounds upon which the Commenters seek to be recognized as interested parties, and JHBMC was entitled to respond to those claims in its Response to the Comments to demonstrate that the Commenters do not qualify to be interested parties. Not only was it appropriate for JHBMC to respond to the Commenters' arguments regarding standing in its Response, the Commission's regulations require that JHBMC's Response include these matters. COMAR 10.24.01.08F(3) states that the applicant "is permitted to make one written filing responding to all written comments on its application within 15 days of receipt of those comments." Had JHBMC's Response not addressed the Commenters' assertions regarding standing in its Response, it could have waived the opportunity to respond altogether.

Nor does the regulation governing motions practice relied on by the Commenters require JHBMC to file a motion. It requires a motion to seek "an action that might be initiated properly or undertaken by a party to a review, and that is not otherwise provided for in these regulations." (Emphasis supplied). The Commission's regulations provide for filings through which a person's standing to be an interested party is determined – specifically, comments filed by the person seeking to be an interested party and the response filed by the applicant. Accordingly, filing a motion is neither required nor appropriate under this regulation.

2. The Commenters Have Not Demonstrated Standing To Be Interested Parties.

The Commenters argue in their Reply Comments that the Reviewer has the sole discretion whether to grant them interested party status. To the contrary, the Commission's regulations set forth a strict legal standard that the Commenters are required to meet in order to qualify as an interested party. Specifically, to be recognized as an interested party, the Commenters must demonstrate that they "would be adversely affected, in an issue area over which the Commission has jurisdiction, by the approval of the project." "Adversely affected" is defined in COMAR 10.24.01.01B(2)(d) to include four categories of persons, and the AFL-CIO relies on (d)(4), which includes a person who:

> ...can demonstrate that the person could suffer a potentially detrimental impact from the approval of a project before the Commission, in an issue area over which the Commission has jurisdiction, such that the reviewer, in the reviewer's sole discretion, determines that the person should be qualified as an interested party to the Certificate of Need review.

Under this provision, the Commenters must first meet the legal standard of demonstrating that they could suffer a potentially detrimental impact from the approval of the project in an issue area over which the Commission has jurisdiction. Only if they meet that standard does the reviewer then have the sole discretion to determine if the Commenters should be qualified as an interested party.

The Commenters' "anything goes" interpretation of .01B(2)(d) makes the language requiring the person to demonstrate a detrimental impact in an issue area over which the Commission has jurisdiction serve no purpose, contrary to the settled rules governing the interpretation of statutes and regulations. Black v. State, 426 Md. 328, 338-39 (2013).

The only reasonable interpretation of the regulation that gives effect to all of its language is that the person must demonstrate to the reviewer a detrimental impact from the approval of the project in an issue area over which the Commission has jurisdiction and, if this demonstration is made, the reviewer has the sole discretion to determine whether the person should be qualified as an interested party. Because the Commenters have not made the required demonstration, there is no discretion to be exercised.

The Commenters argue that administrative standing requirements are more lenient than judicial standing principles, relying on Sugarloaf Citizens' Association v. Department of Environment, 344 Md. 271 (1995). This argument misses the mark. As the Court of Appeals explained in the Sugarloaf case, the lenient standards for administrative standing only apply if there is no regulation specifying a more restrictive standard. Specifically, the Court recognized that: "Absent a statute or a reasonable regulation specifying criteria for administrative standing, one may become a party to an administrative proceeding rather easily." 344 Md. at 286, emphasis supplied. Here, the Commission has adopted a regulation that narrowly defines who may be an interested party in CON reviews, and the Commenters do not qualify under that regulation.

The Commenters next argue that the Commission is not bound by the settled common law standing principles described in JHBMC's Response. Again, this argument misses the mark. First, the Commenters do not qualify as interested parties under the plain language of the Commission's regulations (without regard to common law standing principles) which require the alleged adverse impact (1) be in an issue area over which the Commission has jurisdiction, and (2) result from the approval of the project before the Commission. Here, the adverse impact claimed by the Commenters (affordable housing)

is not an issue area over which the Commission has jurisdiction, and the Comments do not claim any respect in which the approval of this Project (which involves no construction) would result in an adverse impact on affordable housing in any event.

Although the only adverse impact that the Commenters claimed to their organizations in the Comments was an impact on affordable housing, in their Reply, the Commenters tack on a new assertion that they purchase health insurance providing benefits to their employees, dependents and retirees who reside in JHBMC's service area. This claim fails because the Commenters have not demonstrated (or even alleged) how the approval of this project (which would simply align the licensure category of 16 beds with how they have been used for many years and does not involve an increase in rates) would adversely affect them as health insurance purchasers. Further, this claim fails because third party payors are not in the "adversely affected" category of "interested party"; they are in a category of "interested party" of their own under COMAR 10.24.01.01(c). As explained in JHBMC's Response, it would be contrary to the regulation to recognize a person paying premiums to a third party payor as an interested party in the "adversely affected" category when the third party payor itself is not in that category.[1]

Further, while the Commission may not be bound by common law standing principles, it can look to them for guidance in applying its regulation. As described in

[1] Further, if the category of "adversely affected" persons is broad enough to encompass persons who pay premiums to third party payors, it would certainly have been broad enough to encompass the third party payors themselves who are responsible for paying health care bills, leaving no reason to include third party payors as a categorical form of interested party. The regulation defining third party payors as an interested party would be mere surplusage under this interpretation, contrary to settled statutory construction principles. Black v. State, 426 Md. 328, 338-39 (2013).

JHBMC's Response, Maryland courts do not recognize associational or representational standing, but even if the Commission recognizes the potential for an association to be an interested party to represent its members' interests, the Commenters do not qualify for associational standing under the well-settled requirements for associational standing recognized by the Federal courts under which (1) the interests of the members sought to be protected by the association must be germane to the association's organizational purposes, and (2) the members themselves must otherwise have standing as individuals to protect those interests. As explained in JHBMC's Response, the Commenters satisfy neither of these requirements because their organizational purposes (promoting affordable housing) are not germane to the health care-related interests of their members that they seek to protect, and their members would not qualify to be interested parties in their own right.

The Commenters argue that JHBMC confuses what it means to "adversely affected" for purposes of administrative (interested party) standing with being an "aggrieved party" who is entitled to seek judicial review of a Commission decision. To the contrary, the Commission defines "aggrieved party" to mean a person who would be "adversely affected" by the Commission's decision, defined in the same way as it is for purposes of being an interested party in a CON review. Specifically, under COMAR 10.24.01.01B(3), "aggrieved party" means an interested party who filed written comments and "would be adversely affected by the final decision of the Commission." (Emphasis supplied). Accordingly, the definition of "aggrieved party" (requiring the person to be "adversely affected" by the Commission's decision in order to file a petition for judicial review) reinforces the conclusion that "adversely affected" is to be interpreted consistent

with settled common law principles of standing to determine who should be recognized as an interested party in a CON review.

As explained in JHBMC's Response, granting interested party status to the Commenters would open the door to any employer or person paying health insurance premiums and to advocacy organizations to participate in CON reviews, contrary to the Commission's ongoing efforts to streamline the CON process. In their Reply, the Commenters suggest that the Final Report of the CON Modernization Task Force calls for broadening interested party participation. This is incorrect. The Task Force's Final Report (at 12) recommends the opposite, specifically calling for "more rigorous requirements for obtaining interested party status—higher threshold for demonstrating adverse impact." The language relied on by the Commenters in that Report (referring to the "underdeveloped capability to obtain broader community perspectives on regulated projects") does not refer to interested party status at all. It refers to the lack of informational meetings or public hearings to solicit community input on projects. The Interim Report of the Task Force found that the "capability to obtain broader community perspectives on regulated projects is underdeveloped" explaining (at 13-14) that "[t]he standard CON project review process does not include any requirements for public hearings or any formalized structures for obtaining input from communities or the general public." Accordingly, contrary to the Commenters' suggestion, the Final Report of the Task Force does not call for greater interested party participation, which would be completely contrary to the goal of streamlining the process. Rather, it calls for making the requirements to be an interested party even "more rigorous."

3. The Commenters Fail To Comply With COMAR 10.24.01.08F(1)(d).

As explained in JHBMC's Response, the Comments violate COMAR 10.24.01.08F(1)(d) because they were not accompanied by documentation and/or sworn affidavits for factual assertions not in the record. With the Reply, the Commenters filed an affidavit and documentation related to the research they claim to have conducted into JHBMC's medical debt lawsuits. The Commenters were required to submit such information within 30 days after the Application was docketed as required by COMAR 10.24.01.08F(1)(d), so the untimely filing of this information over 60 days after the Application was docketed does not cure the deficiency of their Comments. The regulation does not allow a person seeking interested party status to spread the comments and required support over multiple filings as the Commenters have done here.

Further, the affidavit and documentation provided by the Commenters related to the research on JHBMC's medical debt lawsuits that they claim to have conducted is incomplete and inadequate under the regulation. The Affidavit of Michael Rabourn attaches four exhibits, but only authenticates Exhibit 1 (which is a list of cases and case numbers). The Affidavit is silent regarding the other three exhibits, so they have not been authenticated. While not authenticated or described, on its face, Exhibit 2 appears to be a table of zip codes and certain demographic information that states that it is sourced from US Census data, Exhibit 3 appears to be a copy of the table on page 16 of the Comments, and Exhibit 4 appears to be pages of district court case records. Exhibit 4 is a jumble of over 100 pages of documents containing numerous case numbers, without any organization or segregation by case number, and Mr. Rabourn does not tie them to anything in the Comments.

Moreover, Mr. Rabourn does not swear to the accuracy of the conclusions from the research he claims to have conducted. He only swears that he "used standard methods, along with reliable, publicly available Census data, to produce the analysis which appears at ... pp. 9-21" of the Comments. Swearing to the use of standard methods and reliable data to produce an analysis does not constitute swearing that the conclusions from that analysis are accurate. Nowhere does he swear to the accuracy of the many "findings" and conclusions in the Comments, including the allegations regarding the volume of cases and amount/relief sought by year and over 10 years, trends in volume and amount/relief sought in lawsuits over 10 years, and the bullet points and table on pages 14-15 of the Comments alleging demographic information about the zip codes alleged to have the most medical debt lawsuits filed by JHBMC, and the bullet points and table on pages 15-16 alleging the demographic characteristics of unspecified zip codes where some medical debt defendants are alleged to reside. Nor does he show any of the underlying calculations for any of these conclusions so that they could be verified.

Further, in conducting his analysis, Mr. Rabourn relied on data provided by the American Federation of Labor-Congress of Industrial Organizations which he states compiled the list of JHBMC medical cases in the Maryland Judiciary data base (while he only conducted a sample review for "quality control") (see ¶¶7-9). However, no person from the AFL-CIO has sworn under oath to have compiled the list, so the linchpin of Mr. Rabourn's affidavit is unsupported by sworn affidavit.

Lastly, the Commenters provided no sworn affidavit to support the factual allegations to demonstrate standing, so the Comments continue to violate COMAR 10.24.01.08F(1)(d) and fail to support granting the Commenters interested party status.

4. The Applicant Satisfies The Quality Of Care Standard.

As explained in JHBMC's Response, JHBMC's Application provided its performance on the applicable quality metrics under the Acute Care Chapter (COMAR 10.24.09.04A(2)(b)), demonstrating that it scored better than average or average on two-thirds of the quality measures and explaining the actions it had already taken to improve performance on the other measures. Similarly, as required by the Acute Inpatient Rehabilitation Services Chapter (COMAR 10.24.10.04A(3)(b)), JHBMC reported its performance on the applicable quality metrics, under which patient falls was the only measure that it did not meet or exceed the target. JHBMC provided detailed information on the steps it had already taken to reduce patient falls which had already reduced the number of falls.

The Commenters suggest that the State Health Plan standards require an applicant to be average or above average on every performance metric. This claim is belied by the plain language of the standards. The Acute Care Chapter requires an applicant with any measure value below the targets to "document each action it is taking to improve performance for that Quality Measure." COMAR 10.24.10.04A(3)(b). Likewise, the Rehab Chapter requires the applicant to "meet quality of care standards or demonstrate progress toward reaching these standards ...." COMAR 10.24.09.04A(2)(b)(emphasis supplied). Far from requiring an applicant to meet or exceed the target on all measures, both standards contemplate that applicants will not

meet the target on all measures by specifying what applicants must demonstrate in instances where they fall short.

The Commenters rely on the first sentence in .04A(3) ("an acute care hospital shall provide high quality care") to support their claim that an applicant may not score below average on any quality metric. This interpretation would nullify the remainder of the standard requiring an applicant to document remedial actions and progress towards meeting or exceeding any metric on which it is below the target. Read as a whole, the standard requires the applicant to provide high quality care, as demonstrated by meeting the requirements of .04A(3)(a) and (b), requirements that it is undisputed JHBMC has met.

With regard to patient falls specifically, the Commenters do not dispute that as a result of remedial steps taken by JHBMC, the rate of falls dropped to below average. They assert, however, that "more time is needed" to demonstrate progress. The Commenters' argument is again far afield from the State Health Plan standard, which only requires the applicant to demonstrate progress towards meeting the standard. Nothing in the standard allows or requires a CON to be delayed until the applicant demonstrates not just progress towards meeting the standard, but that the standard has been met and maintained for more than six months.

The Commenters question how the conversion to nearly all private rooms (which is part of the project under review in Docket No. 24-84-2414) will help reduce the wait times in JHBMC's emergency department. The Commission has approved many CONs in the last several years for conversions to private rooms, recognizing that it reduces the need for emergency departments to go an ambulance diversion and improves wait times,

among other benefits. See Docket No. 13-15-2368 (Adventist Healthcare, Inc., d/b/a Washington Adventist Hospital CON), and Docket No. 15-15-2368 (Suburban Hospital CON). Having all or nearly all private rooms also improves emergency department throughput because patients do not need to await a room coming available to accommodate acuity, diagnosis, infection control or gender.

5. The Applicant Complies With The Charity Care Standard.

As JHBMC explained in its Response, JHBMC complies with COMAR 10.24.10.04A(2) by providing notice of the availability of charity care in the Patient Handbook (Ex. 6 to Response) prior to admission. In their Reply Comments, the Commenters argue that JHBMC's charity care policy does not state that charity care notice will be provided at the time of preadmission or admission. JHBMC's charity care policy (JHBMC Completeness Response, Ex. CQ1.12, at 1) requires that information about the availability of charity care to be provided before discharge, which is consistent with providing the notice prior to admission.[2] Providing the notice prior to admission (as JHBMC in fact does) is consistent with both the State Health Plan Standard and its charity care policy.[3]

JHBMC's charity care as a percent of total operating expenses is in the second highest quartile of all hospitals in the State. App. at 44. The Commenters argue that

[2] JHBMC's charity care policy and practice reconciles the State Health Plan requirement with the HSCRC requirement in COMAR 10.37.10.26(A)(2) that the information on financial assistance be provided "before discharge" as well as on the patient bill and on request.

[3] As explained in JHBMC's Response, the Reviewer has the discretion to allow JHBMC to modify the Application to provide a revised charity care policy through the process in COMAR 10.24.10.08E(2) (as the Commission recently did in the Prince George's County Hospice Review (Docket Nos. 16-16-2382, 2383, 2384 and 2385) and in the Western Maryland Home Health Review (Docket Nos. 17-R2-2397, 2398 and 2399) or to make a revision to the policy a condition of the CON.

JHBMC should be required to rank even higher in comparison to other hospitals. Under the applicable standard, COMAR 10.24.10.04A(2)(b), however, only hospitals that are in the bottom quartile must demonstrate that the level of charity care they are providing is consistent with the needs of its service area population. JHBMC's level of charity care is far in excess of this standard.

The Commenters complain in their Reply Comments about the placement of the notice of the availability of charity care in the Patient Handbook. The State Health Plan standard does not regulate or provide standards to govern the placement of this notice. Further, JHBMC's notice is appropriately placed in the Patient Handbook in the section on "Medical Records/Bills and Insurance" and under the prominent subheading "Patient Billing and Financial Assistance". See JHBMC Response, Ex. 6 at 14. The Patient Handbook provides a variety of other important information to patients, including privacy information, patient rights and responsibilities, health and safety information, including medication safety and pain management information, and information on the patient's experience while in the hospital, and the discharge process, among other things. The notice of financial assistance is given appropriate placement and prominence in the Patient Handbook, and there is no basis to require that it be given greater prominence than any of the other vitally important information provided to patients in the handbook.

The Commenters claim in their Reply that JHBMC's charity care policy does not comply with the State Health Plan Standard because it states that a patient must be "a U.S. citizen or permanent legal resident or permanent legal resident (must have resided in the U.S.A. for a minimum of one year." JHBMC Completeness Response, Ex. CQ1.12, at 4. The language of JHBMC's charity care policy has not changed, so this claim is not

a "reply" to anything new in JHBMC's Response. The Commenters failed to raise this issue in their initial Comments, so this is outside the scope of a reply.

The Commenters do not point to any language in the State Health Plan prohibiting a hospital's charity care policy from making U.S. citizenship an eligibility requirement, suggesting that it can be inferred from the fact that the State Health Plan standard does not explicitly authorize such a requirement. The State Health Plan standard requires a hospital to have a "written policy for the provision of charity care to indigent patients to ensure access to services regardless of an individual's ability to pay." COMAR 10.24.10.04A(2). JHBMC meets this requirement. The State Health Plan standard does not prohibit any eligibility criteria beyond ability to pay.

Moreover, the MHCC does not interpret its charity care standard to preclude a U.S. citizenship requirement, having found the U.S. citizenship requirement to be compliant with the standard in prior CON reviews. For example, in Docket No. 08-24-2289, the Commission granted a CON to JHBMC, finding its charity care policy containing this requirement to comply with the charity care standard. See Exhibit 1 (excerpt from Staff Report and Recommendation), and Exhibit 2 (excerpt from approved charity care policy). It likewise granted a CON to JHBMC in two other cases, Docket No. 11-24-2321 and Docket No. 11-24-2322, finding its charity care policy containing this requirement to comply with the charity care standard. See Exhibit 3 (excerpt from Staff Report and Recommendation in No. 11-24-2321), Exhibit 4 (excerpt from Staff Report and Recommendation in No. 11-24-2322), and Exhibit 5 (excerpt from approved charity care policy in both cases). It also granted a CON to Johns Hopkins Hospital in Docket No. 10-24-2320, finding its charity care policy with identical language to comply with the

standard. See Exhibit 6 (excerpt from Staff Report and Recommendation), and Exhibit 7 (excerpt from approved charity care policy).

Further, JHBMC provides charity care to indigent non-U.S. citizens in its surrounding neighborhoods based on the hospital's Community Health Needs Assessment. These charity care programs include the Care-A-Van, a free mobile medical unit serving uninsured families, mostly Latina immigrants, a prenatal program providing free access to routine obstetric and prenatal services for pregnant women in these neighborhoods, and The Access Partnership which provides access to outpatient specialty care to uninsured patients. All of these programs are provided to patients in these neighborhoods regardless of U.S. citizenship.

The Commenters concede that the medical debt collection practices of hospitals are not regulated by the MHCC, being extensively and exclusively regulated by the HSCRC pursuant to §19-214.2 of the Health-General Article and COMAR 10.37.10.26. It also does not dispute that the number of medical debt lawsuits it claims JHBMC has had over the last ten years represents only a *de minimus* percentage (significantly less than 1 percent) of patient encounters and patients over this period, as shown in Exhibit 9 to JHBMC's Response. The Commenters argue in their Reply that their claims about JHBMC's medical debt collection lawsuits are relevant because they suggest that JHBMC "may be" neglecting to follow its charity care policy. This is pure conjecture by the Commenters and is simply a means to bootstrap irrelevant and baseless claims into this review. There is no evidence that JHBMC is not following its charity care policy and the only evidence is to the contrary.

Moreover, the HSCRC conducts an annual audit of each hospital's compliance with its financial assistance and medical debt collection policies. JHBMC's most recent audit (June 30, 2018) found only two cases in which the policy was not followed, and those two cases involved instances where patients were approved for financial assistance but should have been denied. See Exhibit 8, at 15 (Excerpt from June 30, 2018 HSCRC Audit).

6. There Is No State Health Plan Standard or Criteria Under Which The Commenters Housing Policy Claims Are Relevant.

The Commenters' affordable housing claims continue to be untethered to the State Health Plan and CON review criteria, and from the project that is before the Commission in this review, which involves no construction and would simply convert the licensure category of 16 beds to align it with how the beds have been actually used for many years. In their Reply, the Commenters characterize their Comments as addressing "the negative implications of a CON grant on affordable and equitable housing". Yet nothing in the Comments (or in the Reply) addresses what this project involves, let alone explains how the approval of this project would impact affordable housing in JHBMC's neighborhood. Instead, the Commenters focus entirely on claims about the impact of past development by other Johns Hopkins Health System (JHHS) hospitals over the last 50 years that they allege have contributed to a lack of affordable housing in their neighborhoods, claims that are entirely outside the scope of this review.[4]

[4] Indeed, there is no mention in the Comments or the Reply of any development by JHBMC. As explained in JHBMC's response, JHBMC has been located on the same campus since 1866, and the campus has not grown since JHBMC became part of JHHS in 1984.

There is no State Health Plan standard or review criteria under which the Commission reviews projects to determine their impact on affordable housing or any other housing policy matter. In their Reply, the Commenters argue that the Commission is authorized to look at these issues under COMAR 10.24.01.08G(3)(d) (Viability of the Proposal), suggesting that their concerns about affordable housing are "probative of the availability of community support" for the project. The Commenters again misunderstand the CON review criteria. The Viability criterion requires the Commission to consider "the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames…", and requires the applicant to "describe and document the relevant community support for the proposed project." (Emphasis supplied). The Commenters have not suggested any way in which having (or lacking) the support of their organizations is necessary or relevant to JHBMC's ability to implement this project within the required time frames. Contrary to the Commenters' expansive interpretation, this review criterion is not a vehicle to make a CON review into a forum to litigate housing policy or other policy issues that are outside the Commission's jurisdiction, particularly where, as here, those issues have nothing to do with the project the Commission is reviewing.[5]

[5] The Commenters' claims regarding affordable housing as a social determinant of health likewise miss the mark. This project involves no construction and the Commenters have not alleged any impact that this project would have on affordable housing. Likewise, the fact that JHBMC's 2017 Community Benefits Report identifies housing as a priority in its neighborhood is not relevant since this project will have no impact on housing in JHBMC's neighborhood.

CONCLUSION

For the reasons stated above and in JHBMC's Response to the Commenters' Comments, (1) the Comments and Reply should be dismissed for failure to comply with COMAR 10.24.01.08F(1)(d), and (2) the Commenters should be denied interested party status. Additionally, the Commenters have failed to identify any respect in which JHBMC's Application does not meet the applicable State Health Plan standards so they have not presented any basis to deny a CON in this matter.

Marta D. Harting

Marta D. Harting
Venable LLP
750 E. Pratt Street, Suite 900
Baltimore MD 21202

Counsel for Johns Hopkins Bayview Medical Center

CERTIFICATE OF SERVICE

I certify that on this 11th day of April, 2019, a copy of the foregoing Response to Reply Comments was e-mailed and mailed, first class, postage prepaid, to:

Peter Sobonis
Chelsea Gleason
2424 McElderry Street
Baltimore MC 21205
Peter@nesri.org
Chelsea.gleason@gmail.com

Marta D. Harting

Marta D. Harting

AFFIRMATIONS

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to Comments and Attachments are true and correct to the best of my knowledge, information, and belief.

10 April 2019

Anne Langley
Senior Director
Health Planning and Community Engagement
Johns Hopkins Health System

Date

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to Comments and Attachments are true and correct to the best of my knowledge, information, and belief.

4/11/19

Ed Beranek
Vice President
Revenue Management & Reimbursement
Johns Hopkins Health System

Date

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to Comments and Attachments are true and correct to the best of my knowledge, information, and belief.

Mary M. Sonier

4/11/19

Mary M. Sonier
Director Patient Financial Services
Johns Hopkins Health System

Date

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to Comments and Attachments are true and correct to the best of my knowledge, information, and belief.

Carol C. Sylvester

4-11-19

Carol C. Sylvester
Vice President Care Management Services
Johns Hopkins Bayview Medical Center

Date

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to Comments and Attachments are true and correct to the best of my knowledge, information, and belief.

Spencer Wildonger
Director of Health Planning
Health Care Transformation & Strategic Planning
Johns Hopkins Health System

4/10/2019
Date

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to Comments and Attachments are true and correct to the best of my knowledge, information, and belief.

4-10-09

Tyler Dunn
Administrative Resident
Health Care Transformation & Strategic Planning
Johns Hopkins Health System

Date

EXHIBIT 1

STATE OF MARYLAND

Marilyn Moon, Ph.D.
CHAIR

Rex W. Cowdry, M.D.
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

MEMORANDUM

To: Commissioners

From: Joel Riklin

Date: February 19, 2009

Re: Johns Hopkins Bayview Medical Center
Docket No. 08-24-2289

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Enclosed is a staff report and recommendation for a Certificate of Need ("CON") application filed by Johns Hopkins Bayview Medical Center in Baltimore City. The project is the addition of four operating rooms ("ORs") in renovated space at the hospital and also includes reconfiguration of the pre- and post-operative and support areas for surgical services and an upgrade to the air handling equipment for the surgical area, which includes new construction of a mechanical penthouse. The project includes the renovation of a total of 21,259 gross square feet of existing building space and a total of 1,495 gross square feet of new construction. The project also includes the purchase and installation of a ceiling mounted angiography system in one OR and the purchase of a neuro-navigational device and a computed tomography system on rails that will serve two of the new ORs. While three of the new ORs will have specialized capabilities because of these imaging systems, the Hospital is planning to use all four ORs as mixed use, general purpose rooms. This project first received CON approval on November 22, 2005 (Docket No. 05-24-2165), at a cost of $9.8 million and the project was modified on September 20, 2007, with a cost estimate of $17.9 million.

The project is now estimated to cost $24,352,934 and will be funded through the sale of $12.2 million in bonds, $11.6 million in cash, and a State grant of $560,000.

Commission Staff analyzed the proposed project's compliance with the applicable State Health Plan criteria and standards and the other applicable Certificate of Need review criteria at COMAR 10.24.01.08 and recommends that this project be **APPROVED,** subject to the condition that no rate increase be sought by the Hospital for project-related cost.

IN THE MATTER OF	*	**BEFORE THE**
	*	
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	*	**MARYLAND**
	*	
	*	**HEALTH CARE**
Docket No. 08-24-2289	*	
	*	**COMMISSION**

****

Staff Report and Recommendation

February 19, 2009

(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;

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.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

JHBMC has a policy for providing financial assistance to indigent patients and those with high medical expenses. This policy states that the Hospital will publish the availability of charity care on a yearly basis in the local newspaper and a copy of the latest notice in the Baltimore Sun was included in the application as Exhibit 5. (DI#2, p. 23 and Ex. 5) JHBMC states that it posts notice of the availability of charity care in the Business Office, Admitting Office, and Emergency Room. (DI#2, p. 23) The Financial Assistance policy also states that all applications for financial assistance will be processed within two business days of receipt and a determination will be made as to probable eligibility. (DI#2, Ex. 4, p. 1)

According to the most recent data available from the HSCRC, Bayview provided charity care equal to 4.51% of its operating expenses, which was in the top quartile of all hospitals.

Staff finds that JHBMC is consistent with this standard.

(3) Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the

EXHIBIT 2

The Johns Hopkins Health System Policy & Procedure	Policy Number	FIN034A
	Effective Date	02/01/97
Subject: FINANCIAL ASSISTANCE	Page	1 of 18
	Revised	2/5/08

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), and Johns Hopkins Bayview Medical Center, Inc. (JHBMC)

Purpose

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. JHHS hospitals will publish the availability of charity care on a yearly basis in their local newspaper and will post notices of availability at appropriate intake locations. Notice of availability will also be sent to patients on patient bills.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date;) and any projected medical expenses.

PROCEDURES

1. An evaluation for Financial Assistance can be commenced in a number of ways.

   For example:

   - A patient with a self-pay balance due notifies the self-pay collector 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 charity care evaluation for potential admission.

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, JHOPC first floor administrative staff, Customer Service, etc.

3. When a patient requests Financial Assistance, the staff member who receives the request will refer the patient to the designated person in their clinical or business unit, who will meet with the patient. An assessment will be done to determine if patient meets preliminary criteria for assistance.

   a. All hospital applications submitted will be processed within two business days of receipt and a determination will be made as to probable eligibility. In order to determine probable eligibility applicant must provide family size and family income (as defined by Medicaid regulations). A notice of conditional approval will instruct the applicant of the documentation necessary to complete the application process for a final determination of eligibility.
   b. Applications received will be faxed daily to the JHHS Patient Financial Services Department's dedicated financial assistance application line for review and issuance of a written determination of probable eligibility to the patient.

4. The following criteria must be met in order for a review for a final determination for a Financial Assistance adjustment:

   a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. 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. Review viability of offering a payment plan agreement.

   c. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.

   d. The patient must be a United States of America citizen or permanent legal resident (Must have resided in the U.S.A. for a minimum of one year).

   e. All insurance benefits have been exhausted.

5. There will be one application process for all of Johns Hopkins Medicine. The patient is required to provide the following:

   a. A completed Financial Assistance Application.

   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 US citizenship or lawful permanent residence status (green card).

   f. Proof of disability income (if applicable).

   g. Reasonable proof of other declared expenses.

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor taking the application will review and analyze the application and forward to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines.

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.

   b. If the patient's application for Financial Assistance is based on excessive medical expenses 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 Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications for charity care. It is expected that an application for Financial

EXHIBIT 3

Marilyn Moon, Ph.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
ACTING EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

Memorandum

To: Commissioners

From: Paul Parker

Date: February 16, 2012 pep

Re: Johns Hopkins Bayview Medical Center
Docket No. 11-24-2321

* *

Enclosed is a staff report and recommendation for a Certificate of Need ("CON") application filed by Johns Hopkins Bayview Medical Center in Baltimore. The core of the project is expansion of the emergency department ("ED") facilities of the hospital. The building addition providing the expanded ED facilities will also add dedicated rooms for patient observation. Pediatric facilities are being relocated and reconfigured to the new space as well and the hospital's existing obstetric facilities will expand into the space vacated by pediatrics. The mix of obstetric and pediatric beds will be altered but additional bed capacity designed for inpatients will not be altered. Patient rooms added at JHBMC through this project are designated as observation bed space, used by patients who may be eventually admitted or only observed and discharged without admission.

The total estimated cost of the project is $40,098,889 and the project will be funded primarily through debt ($29.7 million) and cash ($10.1 million). JHBMC states that it "intends" to seek a rate increase in the future to "help fund this project" but no request for a rate increase has been filed with HSCRC.

This project contains no elements that categorically require CON review and approval. The cost estimate, which is well above the current hospital capital expenditure threshold ($10.95 million) requiring approval, is the only basis for this review. The hospital has chosen to obtain CON approval to make a substantive rate increase request possible but could implement this project without CON approval by "pledging" to limit any rate adjustment to a total of $1.5 million.

IN THE MATTER OF	*	**BEFORE THE**
	*	
JOHNS HOPKINS BAYVIEW	*	**MARYLAND HEALTH**
	*	
MEDICAL CENTER, INC.	*	**CARE COMMISSION**
	*	
DOCKET NO. 11-24-2321	*	
	*	

* *

Staff Report and Recommendation

February 16, 2012

COMAR 10.24.10.04A — General Standards.

(1) Information Regarding Charges. *Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:*

Information regarding hospital charges shall be available to the public. Each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

JHBMC states that it "...maintains a representative list of services and charges, which is accessible using a link on the JHBMC patient and visitor services webpage" and it is "available by request in written form" and "updated quarterly." Commission staff has confirmed the availability of a list of services and charges on the JHBMC website. Moreover, the applicant provided a copy of JHBMC's policy describing the list's maintenance procedure and training of staff. JHBMC complies with this standard.

(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.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

JHBMC submitted a copy of its charity care policy and it complies with the requirements of this standard with respect to determinations of probable eligibility, public notice, and individual notice. For example, the policy is published annually in the Baltimore Sun and the applicant states that it is posted in the admissions and ED "and patient billing and financial assistance information is provided..in the Patient Handbook." However, while not required, Commission staff was unable to find JHBMC's charity care policy on its website and recommends that JHBMC assure that its policy can be easily accessed from its patient and visitors page.

JHBMC provided a copy of the reported charity care table from the FY2010 *Community Benefit Report* showed JHBMC to be in the top quartile of Maryland hospitals ranked by level of charity care provided; it ranked 11th among the state's 46 general hospitals, providing more than $21 million in charity care or 4.31% of its total operating expenses.

The applicant complies with this standard.

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

JHBMC documented its current licensure (expiration February 7, 2013) and accreditation status. It is accredited by the Joint Commission (November 7, 2009 for 39 months). JHBMC is in compliance with the conditions of participation of the Medicare and Medicaid programs.

Of the quality measures published by MHCC on its website, JHBMC's performance in 2010 fell in the bottom quartile and was less than 90% for the four measures shown below:

EXHIBIT 4

Marilyn Moon, Ph.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
ACTING EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

Memorandum

To: Commissioners

From: Paul Parker pep

Date: February 16, 2012

Re: Johns Hopkins Bayview Medical Center
Docket No. 11-24-2322

* *

Enclosed is a staff report and recommendation for a Certificate of Need ("CON") application filed by Johns Hopkins Bayview Medical Center ("JHBMC") in Baltimore. The project is development of a comprehensive cancer program facility on the JHBMC campus, centralizing the hospital's oncology/hematology services, which are currently provided in two separate areas of the hospital, and introducing radiation therapy services. The project will involve construction of a new building adjacent to the Bayview Medical Office building the renovation of adjacent space.

The total estimated cost of the project is $26,057,437 and the project will be funded primarily through debt ($19.3 million) and cash ($6.5 million). JHBMC states that it "intends" to seek a rate increase in the future to "help fund this project" but no request for a rate increase has been filed with HSCRC.

This project contains no elements that categorically require CON review and approval. The cost estimate, which is well above the current hospital capital expenditure threshold ($10.95 million) requiring approval, is the only basis for this review. The hospital has chosen to obtain CON approval to make a substantive rate increase request possible but could implement this project without CON approval by "pledging" to limit any rate adjustment to a total of $1.5 million.

IN THE MATTER OF	*	BEFORE THE
	*	
JOHNS HOPKINS	*	MARYLAND HEALTH
	*	
BAYVIEW MEDICAL CENTER	*	CARE COMMISSION
	*	
DOCKET NO. 11-24-2322	*	
	*	

* *

Staff Report and Recommendation

February 16, 2012

written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

Information regarding hospital charges shall be available to the public. Each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

JHBMC states that it "...maintains a representative list of services and charges, which is accessible using a link on the JHBMC patient and visitor services webpage" and it is "available by request in written form" and "updated quarterly." Commission staff has confirmed the availability of a list of services and charges on the JHBMC website. Moreover, the applicant provided a copy of JHBMC's policy describing the list's maintenance procedure and training of staff. JHBMC complies with this standard.

(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.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

JHBMC submitted a copy of its charity care policy and it complies with the requirements of this standard with respect to determinations of probable eligibility, public notice, and individual notice. For example, the policy is published annually in the Baltimore Sun and the

applicant states that it is posted in the admissions and ED "and patient billing and financial assistance information is provided..in the Patient Handbook." However, while not required, Commission staff could not find JHBMC's charity care policy on its website and recommends that JHBMC post its charity care policy on its patient and visitors page to raise awareness by those patients who may have a need for assistance.

JHBMC provided a copy of the reported charity care table from the FY2010 *Community Benefit Report* showed JHBMC to be in the top quartile of Maryland hospitals ranked by level of charity care provided; it ranked 11th among the state's 46 general hospitals, providing more than $21 million in charity care or 4.3% of its total operating expenses.

The applicant complies with this standard.

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

JHBMC documented its current licensure (expiration February 7, 2013) and accreditation status. It is accredited by the Joint Commission (November 7, 2009 for 39 months). JHBMC is in compliance with the conditions of participation of the Medicare and Medicaid programs.

Of the quality measures published by MHCC on its website, JHBMC's performance in 2010 fell in the bottom quartile and was less than 90% for the four measures shown below:

Table 7: JHBMC Bottom Quartile Performance on Quality Measures - 2010

Quality Measure	JHBMC Compliance Level (%*)	State Average Compliance Level (%)	JHBMC Rank	Number of Hospitals Reporting for this Measure (n)
Heart Failure (CHF)				
1. Discharge instructions	75	87	40	45
Pneumonia				
1. Antibiotics within 6 hours	89	95	42	45
2. Influenza vaccination status	80	90	38	44
3. Pneumococcal Vaccination	82	93	41	45

Source: Maryland Hospital Performance Guide, MHCC website and Exhibit 7 of CON application.

EXHIBIT 5

JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTH SYSTEM	**The Johns Hopkins Health System Policy & Procedure** *Subject* FINANCIAL ASSISTANCE	*Policy Number*	FIN034A
		Effective Date	09-15-10
		Page	1 of 19
		Supersedes	01-15-10

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. Acute Care Hospital and Special Programs (JHBMC) and the Chronic Specialty Hospital of the Johns Hopkins Bayview Care Center (JHBCC).

Purpose

JHHS is committed to providing financial assistance to persons 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 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. This should include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt except those accounts on which a lawsuit has been filed and a judgment obtained) and any projected medical expenses. Financial Assistance Applications 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.

JHHS hospitals have experienced an increase in Emergency Room visits from residents of the East Baltimore Community who are not eligible for or do not have any insurance coverage and have demonstrated significant difficulty in paying for healthcare services. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor and disenfranchised, JHHS' hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the JHHS hospitals' commitment to their mission to provide healthcare to those residing in the neighborhoods surrounding their respective hospitals, the JHHS hospitals reserve the right to grant financial assistance without formal application being made by patients residing in the respective hospital's primary service area as defined by the Johns Hopkins Strategic Planning and Marketing Research definition. The zip codes for the JHH primary service area include: (21202, 21205, 21213, 21224, 21231). The zip codes for the JHBMC primary service area include: (21205, 21219, 21222, 21224). The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active Medical Assistance coverage.

Definitions

Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the Hopkins 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

3. Designated staff will 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, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.
   b. Applications received will be sent to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.

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. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.

   c. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).

   d. 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 U.S. citizenship or lawful permanent residence status (green card).

   f. Proof of disability income (if applicable).

   g. Reasonable proof of other declared expenses.

   h. If unemployed, reasonable proof of unemployment such as statement from the Office of

EXHIBIT 6

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IN THE MATTER OF	*	BEFORE THE
	*	
THE JOHNS HOPKINS	*	MARYLAND
	*	
HOSPITAL	*	HEALTH CARE
	*	
Docket No. 10-24-2320	*	COMMISSION
	*	

* *

Staff Report and Recommendation

January 12, 2012

(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;

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.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

JHH's Financial Assistance policy provides for determination of eligibility for charity care or medical assistance, or both, within two business days of application. JHH also provides notice of its Charity Care Policy through publication in the *Baltimore Sun* (the most recent notice published on February 5, 2011 was provided), notices posted in the admissions office, business office and emergency department, and by hardcopy distribution to each patient admitted to the hospital.

According to the most recent data available from HSCRC, JHH provided $36,059,669 in charity care in FY2010, equal to 2.27 percent of its operating expenses and placing it in the second quartile for all hospitals ranked by this charity care measure. JHH complies with this standard, and no further demonstration of the appropriateness of the hospital's level of charity care for its service area population is required under this standard.

(3) Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

EXHIBIT 7

JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	Policy Number	FIN034A
		Effective Date	09-15-10
	Subject	Page	1 of 21
	FINANCIAL ASSISTANCE	Supersedes	01-15-10

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. Acute Care Hospital and Special Programs (JHBMC) and the Chronic Specialty Hospital of the Johns Hopkins Bayview Care Center (JHBCC).

Purpose

JHHS is committed to providing financial assistance to persons 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 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. This should include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt except those accounts on which a lawsuit has been filed and a judgment obtained) and any projected medical expenses. Financial Assistance Applications 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.

JHHS hospitals have experienced an increase in Emergency Room visits from residents of the East Baltimore Community who are not eligible for or do not have any insurance coverage and have demonstrated significant difficulty in paying for healthcare services. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor and disenfranchised, JHHS' hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the JHHS hospitals' commitment to their mission to provide healthcare to those residing in the neighborhoods surrounding their respective hospitals, the JHHS hospitals reserve the right to grant financial assistance without formal application being made by patients residing in the respective hospital's primary service area as defined by the Johns Hopkins Strategic Planning and Marketing Research definition. The zip codes for the JHH primary service area include: (21202, 21205, 21213, 21224, 21231). The zip codes for the JHBMC primary service area include: (21205, 21219, 21222, 21224). The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active Medical Assistance coverage.

Definitions

Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the Hopkins 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

Specialists, Administrative staff, Customer Service, etc.

3. Designated staff will 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, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.
   b. Applications received will be sent to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.

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. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.

   c. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).

   d. 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 U.S. citizenship or lawful permanent residence status (green card).

   f. Proof of disability income (if applicable).

   g. Reasonable proof of other declared expenses.

EXHIBIT 8

Johns Hopkins Bayview Medical Center, Inc.

Health Services Cost Review Commission
Compliance Procedures on the Rate Review System
June 30, 2018

We inquired of the Director of Patient Financial Services and were informed that bad debt write-offs do not include denials, outside collection agency's or attorney's expenses. We make no representation regarding the inquiries obtained from the Director of Patient Financial Services.

F. Financial Assistance, Credit & Collection Policies and Recoveries

Financial Assistance

1. Hospitals are required by regulation to post notices in conspicuous places throughout the hospital describing their financial assistance policy and how to apply for free and reduced-cost, medically necessary care.

   - Determine whether such notices are posted.
   - Describe the content of the notices and list where they are posted in the hospital.
   - Determine by inquiry of the appropriate hospital personnel if patients are informed of the availability of financial assistance in any way other than by the posted notices.

   We observed that Financial Assistance Policy notices were posted throughout the Hospital and they described how to apply for free and reduced care. We selected the following departments to observe the notices posted in the main areas of the Hospital:

   - Admissions
   - Physical Therapy Admission
   - Pediatric Emergency Admission
   - Emergency Room
   - Billing
   - Outpatient Registration
   - Otalaryngologist Clinic

   We inquired of the Director of Admission Services whether patients are informed of the availability of financial assistance in any way other than by posted notices. We were informed that included with a new patient's bill is a statement regarding the availability of financial assistance. Also, we were informed that patients receive the Hospital's Handbook when they are initially admitted to the Hospital, which includes information regarding financial assistance. We make no representation regarding the inquiries obtained from the Director of Admission Services.

2. Hospitals are required by regulation to develop an information sheet that shall be provided to the patient, the patient's family, or the patient's authorized representative before discharge; with the hospital bill; and on request.

- Determine if an information sheet is provided before discharge; with the hospital bill; and upon request.
- Does the information sheet include the following items:
  - Description of the hospital's financial assistance policy;
  - Description of patient's rights and obligations with regard to hospital billing and collection;
  - Contact information for the individual or office at the hospital that is available to assist patient or the patient representative in understanding the hospital bill and how to apply for free and reduced cost care;
  - Contact information for the Maryland Medical Assistance Program;
  - Statements that physician charges are not included in the hospital bill and are billed separately

  We obtained the Patient Billing and Financial Assistance information sheet and confirmed through inquiry with the Accounts Receivable Billing Manager that the information sheet is provided before discharge; with the hospital bill; and upon request. We make no representation regarding the inquiries obtained from the Accounts Receivable Billing Manager.

  The Director of Admission Services informed us and we inspected the information sheet, identifying the following items:
  - Description of the Hospital's financial assistance policy;
  - Description of the patient's rights and obligations with regard to hospital billing and collection;
  - Contact information for the individual or office at the hospital that is available to assist the patient or the patient representative in understanding the hospital bill and how to apply for free and reduced cost care;
  - Contact information for the Maryland Medical Assistance Program;
  - A statement that physician charges are billed separately and not included in the hospital bill.

3. Review the hospital's Financial Assistance Policy (provided by the HSCRC). Select a representative sample of 50 cases from the period April 1st through June 30, 2018 of patients who have applied for financial assistance. The sample shall include both patients approved for financial assistance and those who were denied.
   - Determine whether the Financial Assistance Policy was followed:
     - Provide the number of cases and percentage of sample in which the policy was followed 100%.

- Provide the number and percentage of cases in which the policy was not followed.
- When the policy was not followed, provide examples of deviation from the policy and their frequency.

We obtained the Hospital's Financial Assistance Policy, provided by the HSCRC. We obtained the Financial Assistance Applications Report and a sample of 50 cases was haphazardly selected, from the period April 1, 2018 to June 30, 2018, of patients who have applied for financial assistance (listed in Appendix A.4). The sample included both inpatient and outpatient cases. Additionally, the sample included patients approved for financial assistance and those who were also denied. We obtained and inspected patient applications for appropriate evidence of income level requirements to qualify or deny the applicant in accordance with the Financial Assistance Policy.

- See Exhibit VIII for number of cases and percentage of sample in which the policy was followed and was not followed.
- We identified two deviations from the Hospital's Financial Assistance Policy. Two patients were approved for 60% and 20%, respectively, using their net income to calculate the patient's income rather than gross income amounts, as stated per the policy. Using the gross income amounts in accordance with the policy, these patients should have been denied.

4. Determine by inquiry of the appropriate personnel whether or not the Hospital is participating in the Medicaid "Hospital Presumptive Eligibility" provision of the Affordable Care Act. If the Hospital is not participating, ascertain and report the reason why they are not participating.

   We inquired with the Revenue Cycle Manager and were informed that the Hospital participated in the Medicaid Hospital Presumptive Eligibility provision of the Affordable Care Act.

   - For participating hospitals, ascertain and report the process utilized to obtain the necessary patient information to implement the presumptive eligibility process.

     We inquired with the Revenue Cycle Manager and were informed of the below process which is used for presumptive eligibility:

     There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance for the patient 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. The Hospital 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% 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.

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- Report the number of patients that have applied for presumptive eligibility in FY 2018.

  Total Hospital HPE/MHC Applicants: 179

We make no representation regarding the inquiries obtained from the Revenue Cycle Manager.

Credit and Collection Policy

Review the hospital's Credit & Collection Policy (provided by the HSCRC). Select a representative sample of 50 cases that have required collection effort within the last twelve months. The sample shall include both inpatient and outpatient cases and shall include cases from insured as well as self-pay patients, as well as patients who have been granted partial financial assistance, if applicable.

- Determine whether the Credit and Collection Policy was followed:
  1. Provide the number of cases and the percentages of the sample in which the policy was followed 100%.
  2. Provide the number and percentage of cases in which the policy was not followed.
  3. When the policy was not followed, provide examples of deviation from the policy and their frequency.

We obtained the Hospital's Credit and Collection Policy, provided by the HSCRC. We obtained the EPIC billing system patient level aged trial balance and a sample of 50 cases was haphazardly selected that required collection effort within the last twelve months (listed in Appendix A.5). We inspected the billing system comments for documentation of follow-up procedures performed by Hospital personnel or the collection agency. The sample included both inpatient and outpatient cases of insured and self-pay patients. Additionally, this sample included patients who have been granted partial financial assistance (if applicable).

- See Exhibit IX for number of cases and percentage of sample in which the policy was followed and was not followed.
- We identified no deviations from the Hospital's Credit and Collection Policy.

Recoveries

Select a representative sample of 50 cases from the period April 1st through June 30, 2018 where recoveries of bad debts were made (add cases from most recent calendar quarters to reach sample if necessary).

- Determine if the hospital's uncompensated care for the year of recovery was reduced by the full amounts recovered and that the recovered amount is not reduced by collection agency fees or other collection expenses:
  1. Provide the number of cases and the percentage of the sample in which any part of the recovery was applied to the hospital's bad debt expense or reserve;
  2. Of the cases where all or part of the recovery was applied to the hospital's bad debt expense or reserve:

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i. Provide the number of cases and percentages of the sample in which the gross amount of the bill recovered was applied to the hospital's bad debt expense or reserve; and

ii. Provide the number of cases and percentages of the sample in which the gross amount of the bill recovered was not applied to the hospital's bad debt expense or reserve.

We obtained the Hospital's Recoveries Report and a sample of 50 cases was haphazardly selected from the period April 1, 2018 through June 30, 2018 where recoveries of bad debts were made (listed in Appendix A.6).

The Accounts Receivable Billing Manager informed us and we confirmed through inspection of selected cases that the Hospital's bad debt expense or reserve for the year of recovery was reduced by the full amounts recovered and that the recovered amount was not reduced by collection agency fees or other collection expenses. We traced the full recovery amount to the credit description in the EPIC billing system and the collection agency invoice (exclusive of collection agency fees or other collection expenses).

- For 50 cases (100% of the sample) the recovery was applied to the Hospital's bad debt expense or reserve.
- See Exhibit X for number of cases and percentage of sample in which the gross amount of the bill recorded was applied to or not applied to the Hospital's bad debt or reserve.

5. DCFA - Debt Collection/Final Assistance Report

- Debt Collection

1. Verify the names of the collection agency(s) listed against hospital records.

   We obtained a listing of collection agencies and agreed to the EPIC billing system records. The following collection agencies were identified: Nationwide Credit Corporation, Receivable Outsourcing, Inc., Harris & Harris, National Recovery Agency, and UCB Intelligent Solutions.

2. Verify the number of the liens listed against hospital records

   We obtained a listing of liens and agreed to comments in EPIC billing system records and a listing provided by the collection agency. The number of liens identified was 32.

3. Verify the number of extended payment plans against hospital records. Note: Extended patient payment plans exceeding 5 years should be reported.

We obtained a listing of extended payment plans and agreed to EPIC billing system records and a listing provided by the collection agency. Based on inquiry with the Manager of Regulatory Compliance, only extended payment plans in excess of five years are reported in Supplemental Schedule 6. The number of extended payment plans was 23. We make no representation regarding the inquiries obtained from the Manager of Regulatory Compliance.

- Financial Assistance

  1. Verify the number of applications for financial assistance listed against hospital records.

     We obtained the Financial Assistance Applications Report and agreed to the number of applications reported in Supplemental Schedule 6. The number of applications submitted was 595.

  2. Verify the number of applications for financial assistance approved against financial records.

     We obtained Financial Assistance Applications Report and agreed to number of approved applications reported in Supplemental Schedule 6. The number of applications approved was 336.

G. Hospice General Inpatient Services

In March 2001, the Commission approved a Demonstration Project for the provision of general inpatient care to hospice patients to registered Medicare Hospice patients at Maryland hospitals. The project was approved with the following provisions:

- Hospices must bill HSCRC approved rates;
- Hospital may agree to accept reimbursement on a per diem amount other than HSCRC approved rates;
- The balance remaining of the hospital bill for each individual hospice patient after payment of the agreed amount must be written off by the hospital as a voluntary contractual allowance. These voluntary contractual allowances may not be included as uncompensated care in reports submitted to the HSCRC.

Johns Hopkins Bayview Medical Center, Inc.
Summarization of Financial Assistance Sample Results
Base Year Ended June 30, 2018

Exhibit VIII

Total Cases Tested	Total Number of Cases Policy Followed	Percentage of Cases Policy Followed
50	48	96%

Total Cases Tested	Total Number of Cases Policy Not Followed	Percentage of Cases Policy Not Followed
50	2	4%