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

February 25, 2018

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. 18-24-2414

Dear Ms. Potter:

Enclosed are six copies of Applicant's Response to Comments of the American Federation of Labor-Congress of Industrial Organizations.

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. 18-24-2414	*	COMMISSION

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

APPLICANT'S RESPONSE TO COMMENTS OF THE AMERICAN FEDERATION OF LABOR – CONGRESS OF INDUSTRIAL ORGANIZATIONS

The Applicant, Johns Hopkins Bayview Medical Center ("JHBMC"), responds to the comments filed by the American Federation of Labor-Congress of Industrial Organizations ("AFL-CIO") regarding JHBMC's Application for a Certificate of Need ("CON") in this matter.

INTRODUCTION

JHBMC has applied for a CON for capital expenditures associated with a campus redevelopment project that includes the construction of a new inpatient building and the renovation of two existing buildings on its campus (the "Project"). JHBMC lags behind other hospitals in the region in providing modern, state-of-the-art facilities and accommodations for patients, faculty and staff. Application ("App.") at 7. The average age of JHBMC's plant (building and land improvements) is well in excess of the median for other hospitals, and its newest major inpatient clinical building is 25 years old. App. at 63.

The Project will enable JHBMC to transition to nearly all private patient rooms, which has been the design standard for hospitals for more than ten years and is the widespread expectation of patients and their families. App. at 12. The Project will also enable JHBMC to provide modernized and upgraded facilities that offer the highest levels

of patient safety, quality and operational performance. App. at 13. Essential to the long term viability of JHBMC, the Project will allow JHBMC to address quality, safety and service standards, right-size patient rooms, units and operating rooms, upgrade existing outdated infrastructure and enhance infection control. App. at 5. Without this Project, key patient services will be in jeopardy in the short term, and it will threaten JHBMC's ability to maintain its central role as an academic medical center pursuing excellence and innovation in health care delivery, education and research. App. at 7.

The AFL-CIO, a federation of national and international labor unions, filed comments seeking to be recognized as an interested party and requesting the Commission to deny or delay the approval of the Project. Shortly after filing its comments, the AFL-CIO issued a joint press release with National Nurses United, one of its member unions. See Exhibit 1. National Nurses United is currently engaged in union organizing efforts at Johns Hopkins Hospital, another Johns Hopkins Health System ("JHHS") hospital.

As explained below, the AFL-CIO does not have standing to be an interested party in this review. Granting interested party status to the AFL-CIO would also open the door to employers and individuals who pay health insurance premiums as well as a virtually limitless array of associations and organizations without a concrete stake in the approval of the project to claim standing on the same basis as the AFL-CIO. At the same time that the Commission is working to streamline the CON process, creating more contested CON reviews would represent a step in the opposite direction. Further, most of the matters that the AFL-CIO has raised in its Comments are unrelated to any State Health Plan standards and review criteria that govern this review, and relate to matters that are

in the exclusive jurisdiction of the Health Services Cost Review Commission ("HSCRC"), not the Maryland Health Care Commission ("MHCC" or "Commission"), to regulate. In short, the Comments do not identify any respect in which JHBMC's Application is inconsistent with the applicable State Health Plan standards and review criteria, and thus provide no basis for denying the CON.

ARGUMENT

1. The AFL-CIO's Comments Should Be Dismissed For Failure to Comply with COMAR 10.24.01.08F(1)(d)

COMAR 10.24.01.08F(1)(d) requires (emphasis supplied):

> Factual assertions made in comments by a person seeking interested party status that are not included in the record shall be accompanied by appropriate documentation or sworn affidavit, or both.

The AFL-CIO's comments contain numerous factual assertions that are (1) not part of the record in this matter, and (2) not supported by sworn affidavit or appropriate documentation. The AFL-CIO makes several factual assertions to support its request to be recognized as an interested party in this case, none of which are supported by the required sworn affidavit or documentation.[1] Moreover, the AFL-CIO claims (without sworn affidavit) to have conducted a review of all of the medical debt cases filed by JHBMC, Johns Hopkins Hospital and other JHHS hospitals over the last 10 years in the Maryland Judiciary Case Search data base, but provided no documentation of its alleged

[1] These unsupported factual assertions include, but are not limited to, the following: the nature of the AFL-CIO as an organization, the national and international unions that are members of the AFL-CIO, the number of workers represented by the union members of the AFL-CIO, the affiliate local unions representing workers who reside in Maryland, where those workers reside, the local unions' negotiation of health benefits with employers in states, the local unions' joint administration of multi-employer plans, the AFL-CIO's employment of its own staff, where the AFL-CIO's own staff (and their dependents and retirees) reside, and the AFL-CIO's participation in a self-insured multi-employer health plan.

findings.[2] Accordingly, the Comments should be dismissed for failure to comply with COMAR 10.24.01.08F(1)(d). See also COMAR 10.24.01.08F(1)(a)(requiring a person seeking interested party status to file written comments in accordance with the regulation).

2. The AFL-CIO Does Not Have Standing To Be An Interested Party

The AFL-CIO claims that it should be granted interested party status as a person who would be adversely affected by the approval of the project under COMAR 10.24.01B(2)(d) and .01B(20)(e). Specifically, it relies on the definition of "interested party" in COMAR 10.24.01.01B(20)(e) to include "a person who can demonstrate to the reviewer that the person would be adversely affected, in an issue area over which the Commission has jurisdiction, by the approval of the proposed project." The AFL-CIO claims to be "adversely affected" as defined in COMAR 10.24.01.01B((2)(d)(4) as a person who:

> ...can demonstrate to the reviewer 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.

The requirement of this regulation that a person demonstrate "detrimental impact" to establish standing is consistent with settled principles of standing under Maryland common law, which require that a person establish that the person will be aggrieved by the challenged action or decision in order to have standing. Unlike the Federal Courts, Maryland courts do not recognize associational or "derivative" standing, in which an

[2] In Argument Section 3 below, JHBMC will address additional respects in which the AFL-CIO failed to document and/or attest to various factual assertions regarding medical debt collection.

association is afforded standing based on the interests of its members.[3] As the Court of Appeals explained in Voters Organized for the Integrity of City Elections v. Baltimore City Elections Board, 451 Md. 377, 396 (2017)(emphasis supplied, citations omitted):

> [T]his court has not yet recognized such derivative standing. "We have long held the view that, under Maryland common law principles, for an organization to have standing to bring a judicial action, it must ordinarily have a property interest of its own – separate and distinct from that of its individual members – and that ... an organization has no standing in court unless [it] has also suffered some kind of special damage from such wrong differing in character and kind from that suffered by the general public....

The AFL-CIO claims standing both as an organization and as an association acting on behalf of its members.

a. Organizational Standing

In support of organizational standing, the AFL-CIO argues (at 2) that it is "an employer of its own staff [that] participates as one of multiple employers in a self-insured, multi-employer health plan that provides health benefits to active employees, their dependents and retirees ... and their dependents, many of whom reside in the service area of JHBMC." The AFL-CIO does not claim standing under COMAR 10.24.01.01B(20)(2)(c), which defines interested party to include a "third party payor who can demonstrate substantial negative impact on overall costs to the health care system if the project is approved." Nor would there be a basis for it to be given standing as a third party payor because the AFL-CIO is not itself a self-insured plan – it is one of multiple employers who contribute to a multi-employer, self-insured plan. A plan is a separate entity from the employers who contribute to it. The plan, not the contributing employers,

[3] Federal caselaw recognizes "associational standing" only if: (1) an organization's members would otherwise have standing as individuals, (2) the interests at stake are germane to the group's purpose, and (3) neither the claim made nor the relief sought requires the participation of the individual members. See Taubman Realty Group v. Mineta, 320 F.3d 475, 480 (4th Cir. 2003).

pay for health care delivered to enrollees. 29 U.S.C. §1002(1) (ERISA plan includes one that provides or pays for medical care); 29 U.S.C § 186(c)(5) (Taft-Hartley fund pays for benefits). The plan can be sued for a failure to pay benefits owed under the plan. 29 U.S.C 1132(d)(1). In contrast, a contributing employer is not a proper defendant, because it does not have the obligation to pay benefits in the first instance. See Larson v. United Healthcare Ins. Co., 723 F.3d 905 (7th Cir. 2013).[4] Accordingly, as a contributing employer to a self-insured multi-employer plan, the AFL-CIO is no different than any fully insured employer that pays premiums to an insurance company to cover the health care costs of its employees.

Since it cannot claim to be a third party payor, the AFL-CIO relies on its status as an employer in a self-insured plan to become an interested party under .01B(20)(e) as a person who would be "adversely affected" by the approval of the project as defined in .01B(4)(d). Under the AFL-CIO's interpretation of the regulation, any person (individual or group) in the service area who pays health insurance premiums would have standing to be an interested party status in CON reviews. Granting the AFL-CIO interested party status on this basis would be contrary to the regulation. Under .01B(20), third party payors are a categorical form of interested party, alongside (and separate from) staff, the applicant, local health department, and the category of persons who can demonstrate they are adversely affected (as defined in .01B(2)) by the project in an issue area in the Commission's jurisdiction. Thus, third party payors are not "adversely affected" persons

[4] See also Lifecare Mgmt. Servs. LLC v. Ins. Mgmt. Admin. Inc., 703 F3d 835 (5th Cir. 2013) (in an action for benefits, entity that controls the administration of the plan is a proper defendant); Gluth v. Wal-Mart Stores, Inc., 21 EBC 1353 (4th Cir. 1997) (in an action for benefits, entity that does not control plan administration is not a proper defendant)(Ex.2); Wingler v. Fidelity Investments, 57 EBC 1275 (D. Md. 2013) (in an action for benefits, entity with decision-making authority is a proper defendant)(Ex.3).

under the regulation; they are in a category of their own. It would be contrary to the regulation to recognize an employer 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. Further, if the category of "adversely affected" persons is broad enough to encompass employers who pay health care premiums (or contributions) 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 interested party. The regulation defining third party payors as an interested party would be mere surplusage under the AFL-CIO's interpretation, contrary to settled statutory construction principles. Black v. State, 426 Md. 328, 338-39 (2013).

The HSCRC statute provides that "any person ... that contracts with or pays a facility for health care services has standing to participate in Commission hearings..." (Health-General Article §19-227(c)), which has been interpreted by the Court of Appeals to include not only health insurers, but persons to pay premiums to health insurers. Ass'n of HMOs v. HSCRC, 356 Md 581, 589 (1999). In contrast, Health-General Article §19-126(d)(8) grants the MHCC broad authority to define "interested party", which it has exercised through adopting a definition of the term that lists the five specific categories of persons who qualify. It then defined the category of "adversely affected" persons in a way that ensures that only persons with a concrete stake in the matter would have standing as interested parties, consistent with common law standing principles. The definition is limited to (1) existing health care providers that either provide the same service in the same or contiguous jurisdiction or can demonstrate that the project will

materially affect its quality of care or cause a substantial depletion of staff or other resources, and (2) persons who can demonstrate a potentially detrimental impact in an issue area over which the Commission has jurisdiction. Interpreting B(2)(d) to allow any employer or individual in the service area who pays health insurance premiums to qualify as "adversely affected" would be at odds with the painstaking detail with which the Commission defined the categories of existing health care providers who are "adversely affected", requiring them to demonstrate a form of special damage from the project listed in the definition, consistent with the common law standing requirement.

In support of organizational standing, the AFL-CIO also vaguely claims (at 2) that that it could suffer detrimental impact "over the areas of quality of care, cost of health care and entitlement to charity care." None of these vague alleged impacts constitute special damage to the AFL-CIO differing in character and kind from that which might be claimed by any employer (or individual) who pays health insurance premiums. Granting it standing as an interested party on this basis would be contrary to the common law standing requirement for organizational standing described above, under which it must demonstrate that it will suffer some kind of "special damage" from the approval of the project "differing in character and kind from that suffered by the general public."

b. <u>Associational Standing</u>

The AFL-CIO also claims associational (or "derivative") standing on behalf of its members. The AFL-CIO's actual members are "55 national and international unions" (Comments at 1), so it is two steps removed from its members' local affiliates who are alleged to represent workers in the service area, and three steps removed from any workers who live in the service area who are represented by the local affiliate unions.

As described above, Maryland courts do not recognize associational or derivative standing, seeking to ensure that only persons who are adversely affected by the subject of the case in some special and concrete way may participate as parties to litigation. However, even if this form of standing was recognized in Maryland, the AFL-CIO does not meet the standards for derivative standing under the Federal cases that recognize this form of standing.

i. On Behalf of Affiliated Local Unions

In support of derivative standing, the AFL-CIO asserts that unnamed local affiliated unions of the AFL-CIO's members: (1) negotiate with employers over health benefits for employees, and (2) jointly administer multi-employer health plans. Thus, the AFL-CIO seeks to represent the interests, not of its members, but of affiliates of its members. Derivative standing must be based on the association's members, so the AFL-CIO does not have derivative standing to represent affiliates of its members. Taubman Realty, 320 F.2d at 480.

The AFL-CIO does not explain how these unnamed, non-member affiliate local unions would be harmed by the project in their negotiations with employers over health benefits for employees, but detrimental impact on a union's collective bargaining position is not an issue area over which the Commission has jurisdiction in any event. Under COMAR 10.24.01.01B(2)(d)(4) and B(20)(e), an interested party must demonstrate potential detrimental impact in an issue area over which the Commission has jurisdiction. These affiliate local unions could not themselves participate as interested parties by asserting a detrimental impact on their collective bargaining with employers, so the AFL-CIO does not have standing to participate on their behalf on this basis. See Taubman

Realty, supra, 320 F.2d at 480 (association's members must have standing to participate individually in order for associational standing to apply).

The AFL-CIO's claim of detrimental impact on these unnamed, non-member affiliate local unions in their joint administration of multi-employer health plans is also not a basis for interested party status. As described above, the self-insured multi-employer health plans in which these unions participate are the third party payors, not the unions themselves. Accordingly, for the same reason that the AFL-CIO does not have standing to be an interested party under .01B(20)(e) as an employer participating in a self-insured multi-employer health plan, the affiliate local unions likewise do not have standing on this basis.

ii. On Behalf of Workers as Patients

The AFL-CIO also asserts derivative standing to represent the interests of the workers represented by the affiliate local unions as patients/potential patients of JHBMC. The AFL-CIO claims (at 2) that it represents workers who "could suffer detrimental impact if the Certificate of Need is approved over the areas of quality of care, cost of health care and entitlement to charity care...."[5]

The AFL-CIO is a federation of labor unions, but it has cloaked itself here as a patient rights advocacy organization. It seeks interested party status to protect the interests of union members, not as employees, but as patients. Accordingly, the AFL-CIO is not entitled to derivative standing because it is an association of labor unions that represent employees in collective bargaining; it is not a patient rights organization. In

[5] As discussed above, the workers are not the AFL-CIO's members; they are three steps removed from the AFL-CIO as members of the affiliated local unions of the 55 national and international unions who are members of the AFL-CIO. As a result, the AFL-CIO would not have derivative standing to represent these workers under the Federal case law described above in any event.

order to have derivative standing, the association must seek to protect interests "germane to its purpose." Taubman Realty, supra, 320 F.2d at 480.

If the AFL-CIO is granted interested party status on this basis, it will open the door to become an interested party, not only to labor unions but to other organizations for which advocating for patients is actually germane to their organizational purposes, such as the Maryland Health Care For All Coalition[6], Consumer Health First[7], and Families USA[8]. Likewise, the Health Education and Advocacy Unit of the Consumer Protection Division of the Maryland Attorney General's Office, which assists patients in health care billing and payment disputes, among other things, could seek interested party status in CON reviews on similar grounds.[9]

On the other side, granting interested party status to the AFL-CIO would pave the way for business groups like the Chamber of Commerce and the National Federation of Independent Business to obtain interested party status to protect the interests of their members in controlling health care costs. Nursing home associations could seek interested party status to oppose hospital CON application on behalf of their members, and the Maryland Hospital Association could seek interested party status to oppose nursing home or freestanding ambulatory surgery center CON applications on behalf of its members, as just a few examples.

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[6]Self-described "health care consumer coalition with over 1200 diverse organizational members, including faith, health, community, labor, and business groups from across the state" that seeks to promote "access to quality and affordable health care." http://healthcareforall.com/about/.

[7]Self-described "alliance of individuals and organizations that seeks solutions and advances reforms that promote health equity through access to comprehensive, affordable, high quality care for all Marylanders." http://www.consumerhealthfirst.org/about-consumer-health-first.

[8] Self-described "national voice for health care consumers ... dedicated to the achievement of high-quality, affordable health care and improved health for all. We advance our mission through public policy analysis, advocacy, and collaboration with partners to promote a patient-and community-centered health system. https://familiesusa.org/about.

[9] http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx.

In short, if the AFL-CIO is granted interested party status to protect union members' interests as patients in quality of care, cost of health care and entitlement to charity care, there will be virtually no limit to who can become an interested party in CON reviews. This flies in the face of the Commission's recently completed two-year long effort to find ways to modernize and streamline the CON process. Appendix G to the Commission's Interim Report[10] demonstrates that the average time from application filing to final action is nearly three times as long for contested reviews than for uncontested reviews (704 days vs. 247 days). Exhibit 4. Only 12 of the 49 cases shown on Appendix G (applications filed and completed between July, 2011 and May, 2018) were contested, and that number is likely to dramatically increase going forward if the AFL-CIO is granted interested party status.

Of course, advocacy organizations (and unions) are entitled to participate and advocate for the interests of their members in the Commission's public, quasi-legislative process of developing the State Health Plan standards and regulations that govern the review of CON applications. They are not, however, entitled to be parties to the quasi-judicial CON review process, which should be limited to those who persons who demonstrate the potential for "special damage" from the approval of the project "differing in character and kind from that suffered by the general public." Voters Organized, 451 Md. at 396-97.

3. The Application Complies with the Charity Care Standard

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10 https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/CON_modernization_workgroup/Final%20Report/FINAL_%20INTERIM_REPORT_MODERNIZATION_vol1_052518.pdf

Almost all of AFL-CIO's comments regarding the Charity Care Standard are unrelated to the State Health Plan charity care standard that governs this review. Indeed, it devotes most of its comments to medical debt collection, a matter that is explicitly and exclusively within the jurisdiction of the HSCRC.

The State Health Plan standard governing acute care general hospital projects (COMAR 10.24.10.04A(2)) states: "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." The AFL-CIO's only argument that refers to a standard in the State Health Plan is its argument that JHBMC does not comply with this standard because JHBMC's Charity Care Policy (App. Ex. 7) states that notice will be provided to patients on their bills.

JHBMC fully complies with the State Health Plan requirement that written notice of the availability of charity care be provided to patients at preadmission or admission (COMAR 10.24.10.04A(2)), as well as the similar requirement under the Surgical Services Chapter (COMAR 10.24.11.05A) and under the Obstetric Services Chapter (COMAR 10.24.12.04(3)). Specifically:

- Hospital inpatients -- Patients receive charity care notice in the Patient Handbook (Exhibit 5) at the time of registration.
- Hospital Emergency Department patients – Patients who receive extended care in observation status or are admitted receive charity care notice in the Patient Handbook (Exhibit 5).
- Outpatient clinic patients – Patients receive charity care notice in the Understanding Your Bill" brochure (Exhibit 6) in their appointment packet in the mail prior to the appointment.

- Outpatient surgery patients – Patients receive charity care notice in the Patient Handbook (Exhibit 5) prior to registration, either in the mail or in person when they arrive for services.

- Obstetrics – Patients being admitted receive charity care notice in the Patient Handbook (Exhibit 5) at the time of registration; prenatal outpatient services patients receive charity care notice in the "Understanding Your Bill" brochure (Exhibit 6) in their appointment packet in the mail prior to the appointment; the Community Care-A-Van does direct outreach in the community to uninsured residents who are or may be pregnant, informing them of the no-cost Prenatal Program and enrolling them in that charity program.

In addition to providing charity care notice to patients before admission or provision of service as described above, charity care notice is included on all patient bills (see Exhibit 7), and is posted in the emergency department, at all patient registration sites, at the admissions/business office (see Exhibit 8).

As a result of these and other efforts, JHBMC has achieved a level of charity care that puts it well above the average of all hospitals in the state. Specifically, JHBMC's charity care as a percent of total operating expenses is 2.13%, which is the 20th highest level out of 52 hospitals, consistent with the State Health Plan standard (10.24.10.04A(2)(b)). App. at 50.

The AFL-CIO argues that JHBMC's charity care policy does not explicitly require charity care notice to be provided at the time of preadmission or admission. JHBMC interprets (and applies) its charity care policy to require charity care notice to be provided at the time of admission or preadmission in compliance with the State Health Plan standard. This is demonstrated by the fact that JHBMC does, in fact, provide charity care notice at the required times under the standard as described above.[11]

[11] If the Reviewer concludes that JHBMC's charity care policy needs to be amended in order for the Project to be approvable, the Reviewer has the discretion to allow JHBMC to modify the Application to provide a

The remainder of the AFL-CIO's comments regarding charity care are not based on the Charity Care Standard at all, but instead focus on medical debt collection. Nothing in the Charity Care Standard or any other State Health Plan standard imposes requirements related to medical debt collection. The MHCC does not regulate the medical debt collection practices of hospitals. Medical debt collection by hospitals is extensively and exclusively regulated by the HSCRC pursuant to §19-214.2 of the Health-General Article and COMAR 10.37.10.26. Under §19.214.2(a), each hospital is required to submit to the HSCRC a policy on medical debt collection that meets the requirements of that section. The law requires refunds to patients under certain circumstances, and imposes limits on hospitals' reporting to consumer reporting agency and commencement of legal action. §19-214.2(c), (d). It also imposes various requirements on a hospital's delegation of debt collection to outside collection agencies. §19-214.2(f). Under §19-214.2(h), the HSCRC is required to "review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section." The HSCRC adopted COMAR 10.37.10.26 to implement the requirements of this law.

The HSCRC has long recognized that hospitals must make reasonable efforts to collect medical debt in order to control uncompensated care ("UC") costs that are paid by all payers through the HSCRC's UC funding methodology (and thus part of the total cost of care). The HSCRC explained in a February, 2009 Report (upon which the medical debt collection statute (§19-214.2) was based) that the purpose of its UC funding methodology is "to balance the need to promote efficient collection activity while, at the

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revised charity care policy through the process in COMAR 10.24.10.08E(2), as has been done in several recent CON reviews, or could make this amendment a condition of the CON.

same time, fulfill the [HSCRC's] statutory mandate to fund the reasonable costs of hospital UC [uncompensated care]."[12] As the HSCRC also explained in the same report:

> Of course hospitals must still respond to the requirements of the HSCRC (and the marketplace) that they operate efficiently and effectively, even in their credit and collection activities. Some level of aggressiveness in collection is required to counter-balance the socially irresponsible behavior of some relatively affluent patients who choose not to purchase health insurance, or who actively avoid attempts by hospitals for payment. The Commission believes that any solutions advanced must recognize the balancing act hospitals must play in meeting their multiple goals.[13]

Accordingly, the HSCRC regulates medical debt collection practices under §19-214.2 and COMAR 10.37.10.26 to maintain the proper balance between these objectives. The AFL-CIO's claims about JHBMC's medical debt collection practices are not within the jurisdiction of the MHCC.

In addition to being improper and irrelevant to this review, the AFL-CIO's comments on this subject are misleading and unfounded. The AFL-CIO suggests that the number JHBMC medical debt cases that the AFL-CIO claims to have found in the Maryland courts database evidence an "aggressive pattern" of debt collection. It makes a similar claim about other JHHS hospitals. Looked at in context, however, this claim falls apart. As shown in Exhibit 9, whether looked at as a percentage of unique patient encounters or as a percentage of unique patients, a *de minimus* number (significantly less than 1%) end up in a medical debt lawsuit filed by JHBMC or the other JHHS hospitals highlighted by the AFL-CIO.

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[12] "Report to the Governor: Review of Financial Assistance and Credit and Collection Activities of Maryland Hospitals," Maryland Health Services Cost Review Commission, February 10, 2009 (at p. 8). https://hscrc.maryland.gov/Documents/pdr/GeneralInformation/ReviewFinancialAssistanceCreditCollectionActivities2009.pdf

[13] Id., at 2.

The AFL-CIO claims that JHBMC "targets" zip codes that have higher poverty rates and minority populations for medical debt collection. The table on page 10 of the Comments lists the ten zip codes with the most medical debt lawsuits by JHBMC, along with information about each zip code's poverty levels and racial composition. These zip codes are JHBMC's primary service area. As shown on page 56 of the Application, JHBMC has nine zip codes in its primary service area, and all of them are in the table on page 10 of the Comments, with the tenth zip code in the AFL-CIO's table (21236) in JHBMC's secondary service area. The zip code that accounts for more discharges from JHBMC than any other zip code (21222) is also the zip code with the most medical debt cases (App. at 56). The AFL-CIO's Comments simply demonstrate the unsurprising fact that most of JHBMC's medical debt lawsuits come from within its primary service area.

Further, the claims in the bullet points on page 11 of the Comments are completely unsupported by underlying data.[14] There is nothing contained in, or attached to, the Comments showing how the percentages of cases were calculated; without knowing what areas or zip codes the AFL-CIO is referring to and having the demographic data it used, there is no way to verify the accuracy of the claims in those bullet points, let alone to enable JHBMC to specifically respond to them. As explained above, the AFL-CIO's Comments should be dismissed because it failed to document its claims and provide sworn affidavits as required by COMAR 10.24.01.08F(1)(d). The bullet points on page 11 are another example of the AFL-CIO's failure to comply with this requirement.[15]

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[14] While the AFL-CIO has not attested to its alleged findings from reviewing JHBMC's medical debt cases, assuming the total number of cases and breakdown by zip code in the table at the bottom of page 11 are accurate, the first bullet point on that page is the only one that can at least be calculated from information provided in the Comments. Specifically, 316 (13%) of the 2,373 cases come from these zip codes, all of which are in JHBMC's service area.

[15] The AFL-CIO's case examples (only two of which are JHBMC cases) are further examples of its failure to provide appropriate documentation of its factual assertions in violation of the regulation. Each case

Accordingly, the AFL-CIO's claims about medical debt collection are not a subject of the MHCC's jurisdiction, but they are also misleading and unfounded. The AFL-CIO's Comments do not demonstrate any respect in which the Project does not comply with the applicable Charity Care Standard in the State Health Plan.

4. The Rate Increase Assumed in The Application Is Consistent with the Applicable State Health Plan Standards and Review Criteria

The State Health Plan standard that applies when a hospital intends to seek a rate increase from the HSCRC to account for the increase in capital costs associated with the project is COMAR 10.24.10.04B(4)(Adverse Impact), which provides in pertinent part:

> A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:
>
> (a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. If the project involves replacement of physical plant asset, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project....

In response to this standard, JHBMC explained that it intends to pursue a partial rate application or Global Budget Revenue (GBR) modification with the HSCRC to fund the incremental depreciation and interest expense associated with the Project. App. at

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example in the Comments contains factual assertions far beyond what can be found on the Maryland Courts website under the case number. All that is accessible on the website is basic identifying information of the case (such as the names of the parties) and a list of docket entries. The factual assertions made by the AFL-CIO about the race, age, income, and employment status/earnings of the defendant, as well as the largely illegible pictures of forms contained in the Comments, are not available on the website.

62. Accordingly, to comply with the Adverse Impact standard, JHBMC's response demonstrated that its current unit rates are approximately 20.2% below its Inter-Hospital Comparison (ICC) peer group. It further demonstrated that, after adjusting rates to reflect 100% of projected depreciation and interest costs associated with the Project after markup ($35,140,256), JHBMC's unit rates would be approximately 15.6% below the peer group average. App. at 62-63.

JHBMC satisfied the second requirement of the Adverse Impact standard (age of plant) by demonstrating that its average age of plant ratio (excluding major medical equipment) is 16.1 years, more than 50% older than the median ratio for hospitals of 10.6 years calculated by Standard and Poor's rating service. JHBMC's last major inpatient clinical building will be nearly 30 years old when the new inpatient building proposed as part of the Project would open. JHBMC further demonstrated in the Application that it would be impractical and ineffective to upgrade the current facility to achieve contemporary health care building standards given the limitations of the current structural grid and other space deficiencies. See App, at 63, 65-66.

The AFL-CIO does not dispute the information provided by JHBMC in response to this standard or claim that JHBMC has not complied with the standard. Instead, it argues that the rate increase that JHBMC intends to seek is unwarranted, claiming that the additional interest and depreciation expense resulting from the Project can be accommodated within JHBMC's existing rates and that the rate increase will cause JHBMC's profits to "skyrocket."

There is no State Health Plan standard under which the MHCC decides whether a hospital rate increase is warranted. Whether JHBMC is entitled to a rate increase or

modification of its GBR is a matter to be decided by the HSCRC. In the normal course of this review, the MHCC will seek the input of the HSCRC in order to assist the MHCC in determining whether the Project is viable under COMAR 10.24.01.08G(3)(d), as part of which the HSCRC will review and provide input on JHBMC's financial projections and the underlying methodology and assumptions, including market shift adjustments and the capital-related rate increase to fund incremental depreciation and interest associated with the new inpatient building. Whether the rate increase is warranted is a question for the HSCRC to ultimately decide and is not litigated as part of the CON process.

The AFL-CIO is incorrect in its claim that the rate increase will increase JHBMC's profitability. The rate increase will only fund the incremental interest and depreciation costs associated with the project to prevent a deterioration of JHBMC's profitability as a result of the project. As shown in Exhibit 10, JHBMC already has the 8th lowest operating margin[16] of all hospitals in the State. As shown in Exhibit 11, if the rate increase revenue is removed, JHBMC's operating revenue ratio would be -0.18 in FY23, 0.24% in FY24, and 0.60% in FY25, which could lead to several adverse consequences including a violation of borrowing covenants, rating downgrades, and going concern issues in audited financial statements.

The AFL-CIO also argues that the $48 million in philanthropic support towards the Project assumed by JHBMC in the Application is insufficient, relying on the amount of charitable donations raised in a capital campaign that included all of Johns Hopkins University, and the amount allocated to Johns Hopkins Medicine that includes the School

[16] Operating margin is the ratio of income from operations to net operating revenue. The ratio shown in the AFL-CIO's Table H includes non-operating income. Exhibit 11 adds the correct calculation of JHBMC's operating margin with and without the revenue increase to the table.

of Medicine and the entire Health System. The $48 Million assumed in the Application is the amount of philanthropic support available to JHBMC for the Project. The AFL-CIO's Comments to the contrary are based on sheer conjecture.

Lastly, as to the $36 million in performance improvements, as JHBMC stated in the Application in response to the Viability criteria, the projections "include achievement of projected performance improvements" (App. at 178), and the response to the Completeness question quoted by the AFL-CIO is consistent with this statement.

5. <u>The Applicant Satisfies the Quality of Care Standard</u>

The AFL-CIO claims that "quality performance failures" should delay the issuance of the CON until they have been addressed. The AFL-CIO does not cite to any State Health Plan standard that it claims has not been met by JHBMC.

The State Health Plan standard related to performance on quality measures (10.24.10.04A(3)(b)) provides:

> 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 responded to this Standard and completed the required table and attached it to its Application as Exhibit 12. As shown on Exhibit 12, JHBMC scored better than average or average on two-thirds of the quality measures. For the measures on which it scored below average, JHBMC provided the required information on how it has already taken action to improve performance.

The AFL-CIO does not claim that the Application fails to comply with the COMAR 10.24.10.04A(3)(b). Instead, it selects certain standards on which JHBMC scored below average and claims that the CON should be delayed until this has been "remedied." The State Health Plan standard does not require average or above-average performance on every quality measure. To the contrary, the State Health Plan standard anticipates that hospitals will have below-average performance on some measures because it requires the hospital to summarize what steps it is taking to improve in those areas.

JHBMC has solid overall quality performance. As described above, it scored average or better than average on two-thirds of the Commission's Quality Measures. It rates three stars on CMS Hospital Compare, along with 17 other Maryland hospitals. (There are 14 hospitals in Maryland with ratings of 1 or 2 starts and 20 hospitals with 4 or 5 stars.)[17] See Exhibit 12. JHBMC scores very well compared to other Maryland hospitals on the Combined Quality and Safety Ratings. For Patient Safety, JHBMC is one of only three hospitals that scored "better than average", the highest rating.[18] Exhibit 12. For the combined rating related to deaths, JHBMC is one of only two hospitals in Maryland that scored "better than average".[19] Exhibit 12. In addition, JHBMC has achieved an "A" safety rating from Leapfrog. Exhibit 13. JBHMC meets either "threshold" or "benchmark"

[17] CMS Hospital Compare Overall National Rating combines the results of 64 individual ratings and shows how well each hospital performed, on average, compared to other hospitals in the U.S.
[18] This summary score combines more than one rating related to how well the hospital keeps patients safe into one score.
[19] This summary score combines more than one rating related to the number of patients who die in the hospital into one score, including death as a result of medical conditions and surgeries.

(equating to average and above average) for its private rooms in all of the HSCRC's Quality Based Reimbursement (QBR) measures.[20]

The Commission's Quality Measures for which JHBMC received a "below average" score reflect the need for the project that is the subject of this CON review. For example, JHBMC received lower scores for several measures related to wait times in the emergency department, measures which were highlighted in the AFL-CIO's comments. App. Ex. 12. One of the priorities of this project is to create nearly all private rooms, which will help address these concerns. Private rooms have become the standard for acute care hospitals in Maryland and offer the following benefits (App. at 12):

- Enhanced infection control and capacity for patient insolation;
- Reduction in patient moves to accommodate acuity, diagnosis, infection control, or gender;
- Improved throughput from the emergency department and efficiencies for Admissions staff;
- Physical space and accommodations for family members and other visitors including space for overnight stays;
- Superior patient engagement, confidentiality, and privacy;
- Sufficient space to accommodate clinical equipment, supplies and storage; and
- Reduced ambient noise pollution, especially at night, which improves treatment and recovery for many patient.

AFL-CIO notes that JHBMC received a "below average" score for care for patients with sepsis and septic shock. Medical providers at the bedside have been challenged in identifying "time zero" (the moment the complete set of factors indicating sepsis are recognized) for the patients for the purposes of measurement. After several months of

[20] The QBR program incentivizes and rewards quality improvement across a wide variety of quality measurement domains, including person and community engagement, clinical care, and patient safety. https://hscrc.state.md.us/Pages/init_qi_qbr.aspx.

analysis, JHBMC selected a system that will capture and notify providers of "time zero." JHBMC will implement TREWS: Targeted Real Time Early Warning System to provide clinicians with the necessary information to meet the targets in the sepsis measure, on March 5 in the Emergency Department, and then across the hospital two weeks later. Importantly, JHBMC has a lower than expected mortality rate for sepsis patients, as measured by the Premier Quality Advisor.[21] Exhibit 14.

The AFL-CIO also comments on JHBMC's readmission rate. JHBMC has achieved improvements in the readmission rate, and the work continues. A hospital's readmission rate is influenced by many factors within the hospital's control, and some factors that are not within the hospital's control. The level of socioeconomic disadvantage in a hospital's service area (such as is found in JHBMC's primary service area as highlighted by the AFL-CIO's comments) is strongly correlated to the hospital's readmission rate.[22] While JHBMC will continue to work to reduce the rate of readmissions, it will not likely achieve rates as low as that in hospitals located in more prosperous areas.

JHBMC's readmission rate is also influenced by its Chemical Dependency Unit (CDU), which serves a patient population at high risk for readmission. It is an 18 bed inpatient medicine unit that offers safe medical detoxification for individuals addicted to

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[21] Premier Quality Advisor™ measures and analyzes both hospital and provider performance to improve patient outcomes and reduce costs by integration of quality, safety and financial data. This is accomplished through benchmarking clinical and financial outcomes against peer hospitals; comparing internal and external performances in shaping best decisions; identifying care practice variations; reducing mortality, complications, readmissions and hospital-associated conditions; monitoring ongoing efforts to improve quality, resource utilization, and efficiency; and complying with regulatory reporting requirements. www.premierinc.com

[22] Neighborhood Socioeconomic Disadvantage and 30 Day Rehospitalizations: An Analysis of Medicare Data, Ann Intern Med. December 2, 2014 (Exhibit 15).

alcohol or benzodiazepines. These patients are at high risk for complicated withdrawal from these substances. The average length of stay on the unit is 3 days which means that patients are discharged to continue their treatment journey at other treatment programs in the community. Many of those who come to the CDU have been struggling with their addiction for many years and have a high rate of relapse and readmission to this and other inpatient programs. Because of the high risk of withdrawal complications, when these patients relapse, they will always need medical management when they present in withdrawal, contributing to their readmission risk.

CONCLUSION

For the reasons stated: (1) the AFL-CIO's Comments should be dismissed for failure to comply with COMAR 10.24.01.08F(1)(d), and (2) the AFL-CIO should be denied interested party status. Additionally, its Comments fail to identify any respect in which JHBMC's Application does not meet the applicable State Health Plan standards so they do not provide 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 25th day of February, 2019, a copy of the foregoing Response to Comments of the American Federation of Labor – Congress of Industrial Organizations was emailed and mailed, first class, postage prepaid, to:

Harold C. Becker, Esq., General Counsel
Yona Rozen, Esq., Associate General Counsel
AFL-CIO
815 16th St. NW
Washington DC 20006

Marta D. Harting

Marta D. Harting

AFFIRMATIONS

AFFIRMATION

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

Carl H. Francioli

Carl H. Francioli
Vice President, Finance
Johns Hopkins Bayview Medical Center

2-22-2019
Date

AFFIRMATION

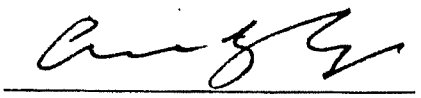
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Mary M. Sonier
Director, Revenue Cycle Management
Johns Hopkins Health System

February 25, 2019

AFFIRMATION

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

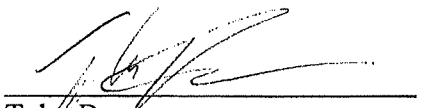


Anne Langley
Senior Director
Health Planning and Community Engagement
Johns Hopkins Health System

21 Feb 2019
Date

AFFIRMATION

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



2-22-19

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

Date

AFFIRMATION

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

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

2/22/2019
Date

AFFIRMATION

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

Carol C Sylvester

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

2-22-19
Date

AFFIRMATION

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

Janet McIntyre

Janet McIntyre, RN, MSN, CPHQ
Senior Director, Quality Management
Johns Hopkins Bayview Medical Center

2-25-2019
Date

AFFIRMATION

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

Lisa Filbert

2/22/19
Date

Lisa Filbert, RN, MS, NHA
Chief of Staff, Johns Hopkins Bayview Medical Center