IN THE MATTER OF	*	BEFORE THE
JOHNS HOPKINS	*	MARYLAND
BAYVIEW MEDICAL CENTER	*	HEALTH CARE
Docket No. 18-24-2414	*	COMMISSION

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

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

The Applicant, Johns Hopkins Bayview Medical Center ("JHBMC"), responds to the Reply Comments filed by the American Federation of Labor-Congress of Industrial Organizations ("AFL-CIO") on March 8, 2019. JHBMC filed a Motion to strike the AFL-CIO's Reply Comments on March 18, 2019 on grounds that the filing is contrary to COMAR 10.24.01.08F. If the Commission does not strike the Reply Comments, JHBMC responds to the Reply Comments as set forth below.

1. Lack of Documentation/Sworn Affidavits (COMAR 10.24.01.08F(1)(d))

As explained in the Applicant's Response to the AFL-CIO's original Comments, the Comments should be dismissed for failure to attach sworn affidavits or appropriate documentation of numerous factual assertions outside the record as required COMAR 10.24.01.08F(1)(d). The AFL-CIO's Reply Comments do nothing to address or remedy that deficiency.

The unsupported factual assertions in the original Comments include all of the facts asserted by the AFL-CIO in support of its standing to be an interested party in this matter, as well as all of the alleged facts regarding the review it claims to have conducted of JHBMC's medical debt lawsuits over the past 10 years. In its Reply Comments, the AFL-CIO argues that it is not required to comply with COMAR 10.24.01.08F(1)(d)

because its factual assertions in support of its standing to be an interested party are "true on their face and commonly known." There is no exception from the requirement in COMAR 10.24.01.08F(1)(d) to provide a sworn affidavit and/or appropriate documentation for factual assertions because the filer proclaims them to be "true on their face and commonly known." To the extent that the AFL-CIO is attempting to draw an analogy to a court's ability to take judicial notice of facts under certain circumstances, it is settled that facts of which a court "cannot take judicial notice are facts about the parties and their activities, businesses and properties..." Trial Handbook for Maryland Lawyers §20.1 (3d ed.); Abrishamian v. Washington Medical Group, P.C., 216 Md. App. 386, 414 (2014). All of the factual assertions by the AFL-CIO in support of its standing to be an interested party are about the AFL-CIO itself, its member unions, their local affiliates and their members, where they do business or reside, and their activities including participation in self-insured health benefit plans. Accordingly, these are not facts of which judicial notice could be taken under Maryland law.

Further, there is nothing "true on the face of" or "commonly known" about the factual assertions made by the AFL-CIO in support of granting it standing to be an interested party. For example, the foundation of the AFL-CIO's claim for interested party status is (Comments at 2):

> [T]he AFL-CIO as the employer of its own staff 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 (primary coverage for retirees under 65 and secondary coverage for Medicare eligible retirees) and their dependents, many of whom reside in the service area of JHBMC.

There is nothing true on its face or commonly known about the AFL-CIO's claim that it participates in a self-insured multi-employer plan, or the claim that the plan covers the AFL-CIO's own employees/dependents and retirees and where they reside. Nor is there anything true on its face or commonly known about the factual assertions about the activities of the local affiliate unions of the AFL-CIO's members, none of which are even named in the Comments. The AFL-CIO's claim that these unnamed local affiliate unions represent workers who reside JHBMC's service area is similarly not true on its face or commonly known.

As to its failure to document its findings from the review it claims to have undertaken of JHBMC's (and other JHHS hospitals') medical debt cases in the last 10 year, the AFL-CIO argues that its citation to the Maryland Judiciary's website is sufficient. The Maryland Judiciary website provides a case search engine that gives public access to certain information about cases filed in Maryland courts. A search can be performed by case number and court if known, or by entering a party's name and a date range, which brings up the individual case or list of cases meeting the search criteria. The search cannot be limited to a particular type of case (i.e., medical debt collection). For each case found through the search, only basic case information is available (case status, parties, judgment information and a list of docket entries). The parties' filings and any court orders or rulings in the case cannot be accessed and viewed through the search engine.

Providing the website address for the search engine the AFL-CIO claims to have used to obtain information about JHBMC's medical debt lawsuits over the last ten years does not meet the requirements of COMAR 10.24.01.08F(1)(d). The Comments contain

a series of "findings" (factual assertions) regarding JHBMC's medical debt lawsuits over the past 10 years, including the total number of medical debt cases filed by JHBMC over ten years and in each year; the total amount claimed by JHBMC over ten years and in each year; the median claim amount and minimum claim amount over ten years and in each year, the number of and total amount sought in garnishments, and the total number of cases in which a bankruptcy was involved over ten years and in each year. For the AFL-CIO's findings to be correct, someone must have undertaken a search of cases involving JHBMC in each of the last ten years. From the list of cases generated in each year, the person must have opened and reviewed every case in which JHBMC was the plaintiff, first to determine which ones involved medical debt collection (because the search cannot be limited by type of case), and of those that did involve medical debt collection, determine the amount sought in each case in order to then calculate for that year the total sought, minimum sought and median sought. Further, each case must have been reviewed to determine the number that involve a garnishment in each year and the total and median amount sought, as well as to determine which cases involved a notice of bankruptcy filing.[1]

Accordingly, contrary to the AFL-CIO's suggestion, the accuracy of its factual findings is not demonstrated by simply visiting the Maryland Judiciary website. The research that would have been required for those findings to be accurate requires analysis, skill and judgment. The burden is not on JHBMC or the Commission to recreate

[1] The AFL-CIO's Comments mischaracterize bankruptcies "resulting from" a medical debt lawsuit filed by JHBMC. There is no evidence that any medical debt lawsuit by JHBMC caused a bankruptcy. The case information made available on the Maryland Judiciary website simply reflects when a defendant files notice of filing bankruptcy which gives rise to a stay of further proceedings.

the research and analysis the AFL-CIO claims to have conducted in order to verify the accuracy of its findings from the research.

The AFL-CIO concedes in its Reply Comments (at 5) that factual assertions in its "case examples" were not from the Maryland Judiciary website, and claims instead that they were based on reviewing the case files at the District Court. The AFL-CIO claims that it documented these assertions with the three pictures of forms pasted into its Comments. In addition to being largely illegible, those forms do not have the case number on them, so they could have come from any case. Without a sworn affidavit attesting that these forms were actually JHBMC cases, they do not document anything.

2. Interested Party Standing (COMAR 10.24.01.01B(2), (20)

The AFL-CIO argues in its Reply Comments that the reviewer has the sole discretion whether to grant it interested party status. This is incorrect. The Commission's regulations set forth a strict legal standard that the AFL-CIO is required to meet in order to qualify as an interested party. Specifically, to be recognized as an interested party, the AFL-CIO must demonstrate that it "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 AFL-CIO must first meet the legal standard of demonstrating that it could suffer a potentially detrimental impact from the approval of the project in an

issue area over which the Commission has jurisdiction. Only if it meets that requirement does the reviewer then have the sole discretion to determine if the AFL-CIO should be qualified as an interested party.

The AFL-CIO's "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 AFL-CIO has not made the required demonstration, there is no discretion to be exercised.

The AFL-CIO argues 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 AFL-CIO does not qualify under that regulation.

The AFL-CIO argues that the Commission is not bound by the settled common law standing principles described in JHBMC's Response. Again, this argument misses the mark. While the Commission may not be bound by those principles, it can look to them for guidance in applying its regulation. As explained in JHBMC's Response, the requirement in .01B(2)(d) that a person demonstrate "detrimental impact" from the approval of the project is consistent with (and should be interpreted in light of) settled principles of standing under Maryland common law which require that a person demonstrate some kind of "special damage ... differing in character and kind from that suffered by the general public." Voters Organized for the Integrity of City Elections v. Baltimore City Elections Board, 451 Md. 377, 396 (2017).

The AFL-CIO argues 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 AFL-CIO 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 its Reply Comments, the AFL-CIO suggests 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 AFL-CIO 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."

3. Charity Care Standard (COMAR 10.24.10.04A(2))

As JHBMC explained in its Response, JHBMC complies with this standard by providing notice of the availability of charity care in the Patient Handbook (Ex. 6 to Response) prior to admission. In its Reply Comments, the AFL-CIO argues 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 (App. Ex. 7, 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 50. The AFL-CIO argues in its Reply Comments that 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 AFL-CIO complains in its 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

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[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.

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 AFL-CIO claims in its Reply Comments 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." App. Ex. 7, 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 AFL-CIO failed to raise this issue in its initial Comments, so this part of its Reply Comments should be stricken as outside the scope of a reply.

The AFL-CIO does 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 state that the policy must apply to all indigent patients so as to preclude 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, as described in the CON Application (at 10) and as stated in its charity care policy, JHBMC provides charity care to indigent non-U.S. citizens in its surrounding neighborhoods based on the hospital's Community Health Needs Assessment. See App. Ex. 7, at 6. 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 AFL-CIO's claim that JHBMC is receiving more in rates than it provides charity care is likewise without merit.[4] It provides a table purporting to show "Charity Care Provided," "Charity Care Rate Support," and "Rate Support in Excess of Charity Care Provided" for fiscal years 2015, 2016, and 2017. The values stated for "Charity Care Provided" are those reported by JHBMC each year to the HSCRC in the hospital community benefit report. JHBMC reported the following charity care amounts since FY12:

FY12	FY13	FY14	FY15	FY16	FY17	FY18
$25,308,100	$26,313,000	$22,183,000	$16,531,000	$12,679,000	$16,951,000	$18,957,000

The drop observed in FY15 and FY16 followed implementation of the Affordable Care Act and the increased availability of insurance coverage. Since FY16, the amount of charity care provided by JHBMC has been on an upward trend. The values stated in the Comments as "Charity Care Rate Support" are estimated numbers. Under the HSCRC's Uncompensated Care (UC) methodology, hospitals don't receive specific amounts in rates for Charity Care, they receive money in rates for Uncompensated Care which is the combination of Charity Care and Bad Debt. A hospital's revenue two years prior and estimated revenue for the coming year are used to estimate the amount of UC a hospital

[4] This argument should be stricken because it is based on new information that is, like the claim regarding the U.S. citizenship requirement in JHBMC's charity care policy, outside the scope of reply since it could have been raised in the AFL-CIO's Comments. Further, it alleges a matter that is within the exclusive jurisdiction of the HSCRC.

will receive in rates that year. The HSCRC makes an approximation of the breakdown of the two components based on the actual breakdown from a prior year. At any point in time, some hospitals are funded more UC in rates and some are funded less than their actual experience because the estimated amounts are based on a regression methodology. Exhibit 8 (attached) shows JHBMC's UC included in rates, its actual UC, and the statewide average UC for FY14-18. Prior to FY15, JHBMC's actual UC exceeded both the amount in rates and the statewide average. After being nearly equivalent in FY15, JHBMC's UC in rates exceeded its actual UC for FY16 and 17. In FY18, once again, the lines cross as JHBMC's actual UC exceeds the amount in rates. This pattern is unsurprising given the HSCRC methodology.

The AFL-CIO concedes 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 AFL-CIO argues in its Reply Comments that its 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 AFL-CIO and is simply a means to bootstrap its undocumented and unsworn research "findings" 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 9, at 15 (Excerpt from June 30, 2018 HSCRC Audit).

4. Adverse Impact (COMAR 10.24.10.04B(4))

The AFL-CIO argues in its Reply Comments that the Application does not satisfy COMAR 10.24.10.04B(4), quoting only the first sentence of that standard which states that a "capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges...." The AFL-CIO leaves out the rest of the standard which governs how the Commission determines if a project will have an unwarranted adverse impact on charges. In compliance with this standard, JHBMC demonstrated that its current unit rates are approximately 20.2% below its Inter-Hospital Comparison (ICC) peer group, and that after adjusting rates to reflect the 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 also provided the required information to satisfy the second requirement (age of plant). App. at 65-66. The AFL-CIO has not disputed any of this information, either in its original Comments or in its Reply Comments.

In its Reply Comments, the AFL-CIO continues to assert incorrectly that the rate increase will increase JHBMC's profitability, suggesting that it will cause JHBMC's profits to increase by 510% between 2016 and 2025. 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, not to increase profitability. The AFL-CIO's claim that JHBMC will experience an increase in profitability as a result of the rate increase is thus incorrect. Further, its calculation of a 510% increase in profitability is based on total net income (including non-operating income), not operating income. It is inappropriate to include non-operating income because it includes items such as unrealized gains/losses on investments and the impact of changes in the market value of interest rate swaps. The financial performance of these line items is based on directional movements in interest rates and market performance and other volatile economic factors outside of JHBMC's control.

As shown in CON Table H, JBHMC had negative non-operating income in the two most recent actual years in that table, and it projects continued negative results through 2021. Although Table H projects non-operating income to turn positive in 2022-2025, this is dependent on external market conditions that are outside of JHBMC's control. Notably, the 510% increase in total net income calculated by the AFL-CIO (which includes non-operating income) between 2016 and 2025 is largely driven by the fact that JHBMC had a negative $14 million in non-operating income in 2016, the first year of that period.

As shown in Exhibit 10 to JHBMC's Response, JHBMC already has the 8th lowest operating margin of all hospitals in the State. As shown in Exhibit 11 to JHBMC's Response, with the rate increase revenue included, JHBMC projects a modest operating margin of 3.5% in 2023. [5] However, if the rate increase revenue is removed, JHBMC's

[5] Operating margin percentage only increases from 3.3% in 2016 to 3.5% in 2025, largely due to performance improvement projected in the Application.

operating margin would be -0.18 in FY23, 0.24% in FY24, and 0.60% in FY25. In its Reply Comments, the AFL-CIO breezily suggests the Commission need not be concerned about these dangerously low operating margins because JHBMC can rely on the net assets of JHHS to bail it out. This reckless position has no basis in the State Health Plan and is contrary to fundamental requirements of hospital accounting and rate regulation in Maryland.

The AFL-CIO repeats its unsupported claim that $48 Million in philanthropic support is inadequate. Of the $2.86 Billion raised in the recent capital campaign that the AFL-CIO relies on, however, 93% was designated/restricted for a specific purpose, and all but $330 Million was for the School of Medicine. The $48 Million assumed in the Application is reasonable and complies with the State Health Plan Standard.

5. Quality of Care (COMAR 10.24.10.04A(3)(b)

In its Reply Comments, the AFL-CIO largely rehashes the claims in its Comments. As explained in JHBMC's Response, the State Health Plan standard does not require a hospital to have average or above-average scores on all quality metrics. To the contrary, it anticipates hospitals will score below average on some metrics and, in those instances, requires a hospital to explain the steps it is taking to address those areas. In satisfaction of this standard, JHBMC demonstrated that it scored better than average or average on two-thirds of the Commission's quality measures and, on those where it was below average, provided the required information on how it has already taken steps to improve performance. See App. Ex. 12.

The AFL-CIO questions how the conversion to nearly all private rooms 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.[6] 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.

CONCLUSION

For the reasons stated above and in JHBMC's Response to the AFL-CIO's initial Comments, (1) the AFL-CIO's Comments and Reply 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, the AFL-CIO has failed to identify any respect in which JHBMC's Application does not meet the applicable State Health Plan standards so it has not provided any basis to deny a CON in this matter.

Respectfully submitted,

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[6] See Docket No. 13-15-2349 (Adventist Healthcare, Inc., d/b/a Washington Adventist Hospital CON), and Docket No. 15-15-2368 (Suburban Hospital CON). http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_completed.aspx

CERTIFICATE OF SERVICE

I certify that on this 25th day of March, 2019, a copy of the foregoing Response to Comments of the American Federation of Labor – Congress of Industrial Organizations was e-mailed 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

Affirmation

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

25 March 2019

Anne Langley
Senior Director, Health Planning and
Community Engagement
Johns Hopkins Medicine

Date

Affirmation

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

Mary M. Sr, Director, PFS, THHS — 3/25/19

[name and title] — Date

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to Reply 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

3/25/2019
Date

Affirmation

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

Tyler Dunn, Administrative Resident

3-25-19

Date

Affirmation

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

Carl H Francioli

March 25, 2019

Carl Francioli, CPA, CGMA
Vice President, Finance
Chief Financial Officer

Date

Affirmation

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

[name and title]

Jeremy R. Durkin
Data Analytics Manager

3/25/2019
Date

EXHIBIT 1

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

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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	*Policy Number*	FIN034A
		Effective Date	09-15-10
	Subject FINANCIAL ASSISTANCE	*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

l

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;

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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

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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

Summary of UCC

FY 2014 - FY 2019 (Projected)

		FY 2014	FY 2015	FY 2016	FY 2017	FY 2018 (Estimated)
A	UCC in Rates[1]	6.84%	6.15%	5.25%	4.72%	4.49%
B	UCC Pool (Payment)/Receipt	0.91%	0.83%	1.73%	1.37%	0.51%
C (A+B)	**Total[1]**	**7.75%**	**6.98%**	**6.98%**	**6.09%**	5.01%
D	Actual UCC[2][6]	8.82%	6.49%	5.10%	4.11%	5.40%
E (C-D)	**Over/(Under) Funding**	**(1.07%)**	**0.49%**	**1.87%**	**1.98%**	(0.39%)
F	Estimated GBR Revenue[3][4]	$581,415,284	$595,773,424	$610,423,590	$620,440,469	$647,476,458
G (E x F)	**Over/(Under) Funding $**	**($6,216,939)**	**$2,925,564**	**$11,427,989**	**$12,297,368**	($2,537,127)

Notes:

[1] Source: HSCRC Statewide Calculation of UCC; based on 50/50 blend of predictive UCC- 2 year actual UCC average

[2] Source: Annual Filings FY2014 - FY2017

[3] Source: PAU Shared Savings Permanent Revenue

[4] FY2014 and FY2015 permanent revenue unavailable; calculated off of FY2016

[5] FY2019 permanent revenue unavailable; calculated as FY2018 revenue inflated by 2.49%

[6] FY2018 'Actual UCC' from FY2018 YTD (June) FSA Schedules; FY2019 Actual UCC estimated at FY2018 level

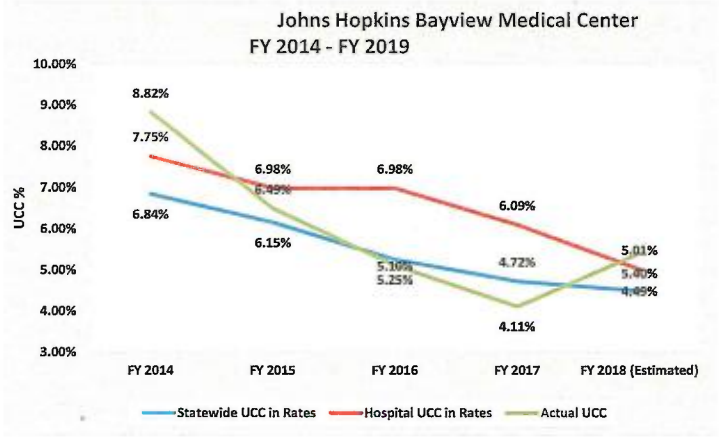

EXHIBIT 9

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.

pwc

- 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.

- 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:

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%