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TO: Commissioners

FROM: Kevin McDonald
Chief, Certificate of Need

DATE: February 20, 2020

SUBJECT: Johns Hopkins Bayview Medical Center, Inc.
Docket No. 18-24-2430

Enclosed is the staff report and recommendation for a Certificate of Need ("CON") application filed by Johns Hopkins Bayview Medical Center, Inc., a 342-bed general hospital located in Baltimore, Maryland. Bayview is also licensed to operate two specialty hospitals. One is a special rehabilitation hospital that is licensed for 12 beds; the other is a special chronic care hospital that is licensed for 76 as chronic beds. Although only 12 of these 88 beds are licensed as rehab, Bayview is currently operating 28 in that capacity. This Certificate of Need application seeks to convert 16 of the chronic beds to rehab.

Because three organizations (United Workers; Charm City Land Trust; and Sanctuary Streets) (Commenters) submitted joint comments contesting the application and seeking interested party status in this review, Commissioner Jeffery Metz was appointed as Reviewer. The Commenters challenged the application in three main areas: (1) quality of care at Bayview; (2) Bayview's financial assistance, charity care, and collection practices; and (3) the impact of development projects on housing and displacement of persons residing in areas affected by hospital development projects. Commissioner Metz ruled that the Commenters did not qualify for interested party status because they failed to demonstrate that any of the Commenters would suffer a potentially detrimental impact from the approval of the project in an issue area over which the Commission has jurisdiction, as provided in COMAR 10.24.01.01B(20)(e) and .01B(2)(d). He based his ruling on his finding that the nature of this project, which consists of bringing existing licensed bed capacity at Bayview into conformance with operational practice, would not change the facilities or services at the hospital in any way that could affect performance on quality measures or Bayview's financial assistance or charity care policies

practices. With regard to the comments about housing and displacement of residents, Commissioner Metz stated that because the project simply seeks to reallocate special hospital bed capacity into licensure categories that align with current use of the beds, and would not change the physical facilities on the Bayview campus, the project should not adversely affect housing near the hospital or elsewhere.

However, Commissioner Metz directed Commission staff to "consider the comments made by the Commenters as staff evaluates the proposed project's compliance with applicable State Health Plan standards and CON criteria." Indeed, staff identified shortcomings in Johns Hopkins Medicine's charity care policy and procedures (used by Bayview) that required a project status conference at which staff identified areas of non-compliance with the charity care standard. Bayview subsequently submitted a revised charity care policy that fixed areas of non-compliance, including the provision of notice to the public and to patients.

The applicant states that the primary driver of the project is a need to bring the bed licensure in line with its current utilization, which increased significantly in 2017 with the termination of a relationship in which members of the Johns Hopkins University School of Medicine faculty were serving as clinical providers at MedStar Good Samaritan Hospital. During 2017, the Hopkins faculty moved to Bayview, and their referrals followed, causing an increase in volume at Bayview. In response, Bayview increased its number of rehab-accredited beds to 28 to meet the demand. Since that time, occupancy rates have remained above 90 percent.

There are no capital expenditures, construction, renovation or operational changes associated with this conversion, and no anticipated changes in the number or type of patients served. Commission staff analyzed the proposed project's compliance with the applicable State Health Plan standards and the other applicable CON review criteria at COMAR 10.24.01.09 and recommends that the project be **APPROVED**.

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

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STAFF REPORT AND RECOMMENDATION

February 20, 2020

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I. INTRODUCTION

A. The Applicant and the Project

The applicant, Johns Hopkins Bayview Medical Center, Inc. (Bayview), is a 342-bed general hospital located at 4940 Eastern Avenue in Baltimore City. It is part of the Johns Hopkins Health System, Inc. (Hopkins), which includes three other general hospitals in Maryland, the Johns Hopkins Hospital in Baltimore, Howard County General Hospital in Columbia, and Suburban Hospital in Bethesda (Montgomery County). The Bayview campus also includes two programs, medical rehabilitation and chronic care, that are licensed as special hospitals. The special rehabilitation hospital is licensed to operate 12 beds and the chronic care hospital has 76 licensed beds.

All of Bayview's special hospital facilities are located in the John R. Burton Pavilion as shown in Table I-1 below. Although only 12 of Bayview's special hospital beds are licensed as rehabilitation beds, Bayview is currently operating 28 beds as rehabilitation beds, the 12 licensed beds and 16 beds licensed for chronic care. This Certificate of Need (CON) application seeks to add those 16 chronic care beds, which Bayview is already using as rehabilitation beds, to its licensed inventory of rehabilitation beds, aligning its licensed bed capacity with current use.

Table I-1: Bayview Special Hospital Bed Capacity
Current and Post-Project

	Current		Proposed	
Floor	**Bed Type**	**Bed Count**	**Bed Type**	**Bed Count**
Burton 01	Rehabilitation	12	Rehabilitation	12
Burton 01	Chronic	8	Rehabilitation	8
Burton 1 C Wing	Chronic	8	Rehabilitation	8
Burton 1 A-B Wing	Chronic	27	Chronic	27
Burton 2	Chronic	33	Chronic	33
	Rehabilitation Subtotal	12	Rehabilitation Subtotal	28
	Chronic Subtotal	76	Chronic Subtotal	60
	Total	**88**	**Total**	**88**

(DI #12, p.7).

The applicant explains that its use of chronic care beds for patients receiving medical rehabilitation came about with the termination of a relationship in which the Johns Hopkins University School of Medicine (JHUSOM) faculty were serving as clinicians at MedStar Good Samaritan Hospital in Baltimore:

> [P]rior to June 10, 2017, JHUSOM faculty were serving as clinical providers at MedStar Good Samaritan Hospital. The relationship terminated on June 10, 2017, concluding a process that included shifting JHUSOM faculty out of MedStar Good Samaritan and into JHBMC. As would be predicted, patients once referred to these JHUSOM faculty practicing at MedStar Good Samaritan Hospital were now being referred to the same JHUSOM faculty…at JHBMC. To respond to this volume shift, JHBMC increased its

number of CARF-accredited beds from 20 to 28 on November 15, 2016.[1] That new capacity was quickly filled, resulting in an occupancy rate that increased from FY17 to FY18. The shift in volume occurred consistent with the shift of the faculty's site of care. The shift is not a 'short-term phenomenon', but the new norm.
(DI #12, p. 9).

Changing the bed capacity of a special hospital requires a CON. Bed licensure is also adjusted annually based on the previous year's occupancy. In this case, Bayview effectively changed the bed capacity of two special hospitals on its campus, the special rehabilitation hospital and the chronic care hospital, by admitting rehabilitation patients to beds licensed as chronic care hospital beds, without obtaining the required approval for those changes from the Maryland Health Care Commission (Commission). This action was contrary to CON law and from the Office of Health Care Quality, contrary to health care facilities licensure law. This became clear to Commission staff when Bayview began reporting an average daily census of rehabilitation patients that exceeded its licensed rehabilitation bed capacity.

There are no capital expenditures, construction, renovation, or operational changes associated with this project. (DI #3, p.5).

B. Staff Recommendation

Staff recommends approval of the project, based on its analysis and conclusions that the proposed project complies with the applicable State Health Plan standards and general CON review criteria, that the need for the project, its cost effectiveness, and its viability have been demonstrated, and that the impact of the project on the health system is positive. However, as noted above, Bayview did not comply with the procedural requirement of obtaining CON approval for a project requiring CON approval prior to implementing the project.

II. PROCEDURAL HISTORY

A. Record of the Review

See Appendix 1.

B. Interested Parties in the Review

Three organizations (the Commenters) submitted joint comments contesting the application and seeking interested party status in this review: United Workers; Charm City Land Trust; and Sanctuary Streets. Their comments and other filings focused on three areas: (1) quality of care at Bayview; (2) financial assistance and charity care, and Bayview's collection practices; and (3) the impact of development projects on housing and displacement of persons residing in areas affected by hospital development projects.

[1] Staff notes that CARF is the Commission on Accreditation of Rehabilitation Facilities.

Commissioner Jeffery Metz was appointed as Reviewer and ruled that the Commenters did not qualify for interested party status because they failed to demonstrate that they would suffer a potentially detrimental impact from the approval of the project in an issue area over which the Commission has jurisdiction, as provided in COMAR 10.24.01.01B(20)(e) and .01B(2)(d). He found that the nature of this project, which consists of bringing existing licensed bed capacity at Bayview into conformance with operational practice, would not change the facilities or services at the hospital in any way that could affect performance on quality measures or Bayview's financial assistance or charity care policies practices. With regard to the comments about housing and displacement of residents, Commissioner Metz stated that because the project simply seeks to reallocate special hospital bed capacity into licensure categories that align with current use of the beds, and would not change the physical facilities on the Bayview campus, the project should not affect housing near the hospital or elsewhere. (DI #34, pp. 3-4). In his ruling, Commissioner Metz also directed Commission staff to "consider the comments made by the Commenters as staff evaluates the proposed project's compliance with applicable State Health Plan standards and CON criteria."

Because staff concluded that the hospital's financial assistance and charity care policies did not meet the requirements of the charity care standard, they convened a project status conference with the applicant on January 28, 2020. At the project status conference, staff stated that it could not recommend approval of the project unless the hospital made specified changes to address standard requirements in the areas of probable determination of eligibility, notice of the availability of charity care, and eliminated a requirement related to citizenship status. The applicant amended its policy and procedures accordingly, effective February 1, 2020.

C. Local Government Review and Comment

No comments on this application were received from the Baltimore City Health Department.

D. Community Support

A letter of support for this CON proposal was submitted by Lisa Filbert and Colleen Carroll, Co- Chairs of the Patient Family Advisory Council for Bayview. (DI #3, Exh. 20).

III. REVIEW AND ANALYSIS

The Commission is required to make its decision regarding this CON application in accordance with the general Certificate of Need review criteria at COMAR 10.24.01.08G(3)(a) through (f). The first of these six general criteria requires the Commission to consider and evaluate this application according to all relevant State Health Plan standards and policies. The State Health Plan chapters that apply are COMAR 10.24.10 (Acute Hospital Services Chapter) and COMAR 10.24.09 (Acute Inpatient Rehabilitation Services Chapter).

A. COMAR 10.24.01.08G(3)(a) – State Health Plan.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

COMAR 10.24.10 – Acute Care Hospital Services
COMAR 10.24.10.04A – General Standards.

(1) <u>Information Regarding Charges.</u>

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:

(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.

The applicant provided a copy of its policy regarding provision of information about hospital charges. (DI #3, Exh. 10). The policy states that hospital charges are updated quarterly and are available on Bayview's website. Estimates of charges for frequently occurring services and procedures are updated quarterly and copies are available upon request from financial counseling staff, whom the applicant states are trained regularly to respond appropriately to the requests for information. (DI #3, p.40).

Staff has reviewed the website and the policy and finds that this standard has been met.

(2) <u>Charity Care Policy</u>

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.

Bayview submitted copies of Hopkins' financial assistance policies and procedures, which it stated are its policies. (DI #36, pp. 1-9). This was an area about which the Commenters made considerable comments. (DI #19, pp. 7-22). As previously noted, after staff reviewed the Hopkins charity care policy and procedures used by Bayview, it concluded that, among other problems, it did not meet the requirement for a two-day determination of probable eligibility or comply with the requirement to provide patients with individual notice of these policies prior to the provision of services. Staff outlined these shortcomings in a project status conference, at which Commission staff recommended specific changes to the policy. Bayview submitted a revised charity care policy, which was effective on February 1, 2020. (DI #36). The new policy's alignment with the subparts of this standard is addressed below.

(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.

Bayview's revised policy states that it will make an initial determination of probable eligibility within two business days following the initial request for financial assistance or application for Medical Assistance, and communicate the determination to the patient and/or the patient's representative. The determination will be based on information provided by the patient (or representative) about family size, insurance, and income. No application form, verification, or documentation of eligibility will be requested or required for the determination of probable eligibility for charity or reduced fee care, although such information will be required for a final determination of eligibility. (DI #36, p.3).

Staff concludes that Bayview complies with Subparagraph (i) of the charity care standard.

(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;

Bayview states that it publishes notices of Financial Assistance annually in local newspapers in a format understandable by the area population. (DI #36, p.7). Staff verified via the hospital's website that the applicant also provides copies of the Financial Assistance policy in Chinese, Farsi, French, Japanese, Korean, Portuguese, Russian, Spanish, Tagalog and Vietnamese.

Staff concludes that Bayview complies with Subparagraph (ii)1 of the standard.

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

The applicant states that notices are posted at patient registration sites, its admissions, business and billing offices, and its emergency department. (DI #36, p.7). The applicant states that it also posts a notice about the availability of charity care on its website and includes information about the availability of charity care with patient bills. (DI #36, p.7). Staff has verified that this information is on Bayview's website.

Staff concludes that Bayview has met the requirements of Subparagraph (ii)2 of the standard.

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.

Hopkins' revised policy states that "individual notice regarding the hospital's financial assistance policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital." (DI #36, p.7). Staff concludes that the revised policy complies with Subparagraph (ii)3 of the charity care standard.

(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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

The *Maryland Hospital Community Benefit Report FY2017*, which was the most recent published report from the Health Services Cost Review Commission (HSCRC) at the time of the application, shows that Bayview reported that it provided charity care with a value equivalent to 2.76 percent of operating expenses, placing it within the top quartile of Maryland general hospitals, as shown in the chart below.

Commission staff consulted the more recent *Maryland Hospital Community Benefit Report FY2018* and notes that Bayview remains in the top quartile, reporting the provision of charity care with a value equivalent to approximately three percent of its operating budget.

Staff concludes that Bayview complies with Paragraph (b) of the charity care standard.

Table III-1: Levels of Charity Care Reported by Maryland General Hospital Maryland Hospital Community Benefit Report, FY2017

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	Charity Care as a % of Operating Expenses
Carroll	$197,802,000	$790,716	0.40%
Greater Baltimore	$419,396,862	$2,085,315	0.50%
Anne Arundel	$561,392,000	$4,450,854	0.79%
Shore at Chestertown	$46,048,000	$373,000	0.81%
MedStar Montgomery	$160,725,287	$1,322,823	0.82%
LifeBridge Sinai	$727,868,000	$6,526,756	0.90%
Union	$157,260,383	$1,411,673	0.90%
Johns Hopkins	$2,307,202,000	$21,697,000	0.94%
MedStar Union Memorial	$443,482,532	$4,426,976	1.00%
MedStar Franklin Square	$508,539,888	$5,147,814	1.01%
UM Upper Chesapeake	$284,219,000	$3,014,000	1.06%
Suburban	$283,346,000	$3,168,000	1.12%
AHC Shady Grove*	$323,661,835	$3,646,551	1.13%
Lifebridge Northwest	$240,547,439	$2,734,207	1.14%
MedStar Southern Maryland	$243,629,886	$3,014,042	1.24%
UM Charles Regional	$117,918,178	$1,474,409	1.25%
Howard County General	$260,413,000	$3,368,222	1.29%
University of Maryland	$1,470,095,000	$20,308,000	1.38%

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	Charity Care as a % of Operating Expenses
MedStar Good Samaritan	$282,735,786	$4,078,427	1.44%
MedStar St. Mary's	$168,757,516	$2,458,649	1.46%
Shore at Easton	$190,646,000	$2,786,102	1.46%
Meritus	$309,163,913	$4,596,841	1.49%
Shore at Dorchester	$42,909,000	$647,362	1.51%
MedStar Harbor	$187,002,302	$2,816,043	1.51%
UM St. Joseph	$341,335,000	$6,105,000	1.79%
E.W. McCready Memorial	$16,564,839	$307,205	1.85%
Peninsula Regional	$432,141,737	$8,301,400	1.92%
Calvert	$135,047,535	$2,694,783	2.00%
UM Baltimore Washington	$334,210,000	$6,703,000	2.01%
UM Rehabilitation and Orthopaedic	$107,006,000	$2,271,000	2.12%
Ft. Washington	$42,883,433	$928,769	2.17%
Atlantic General	$117,342,233	$2,569,517	2.19%
UM Harford Memorial	$84,926,000	$1,927,000	2.27%
Frederick Memorial	$350,118,000	$8,081,000	2.31%
Sheppard Pratt	$221,570,405	$5,473,873	2.47%
UMMC Midtown	$204,226,000	$5,174,000	2.53%
UM Laurel Regional	$93,884,647	$2,521,365	2.69%
Johns Hopkins Bayview	$613,834,000	$16,951,000	2.76%
Holy Cross Germantown	$97,124,985	$2,819,650	2.90%
Mercy	$464,031,500	$14,411,600	3.11%
UM Prince Georges	$286,955,092	$9,166,191	3.19%
Western Maryland Regional	$322,835,314	$10,385,555	3.22%
Adventist Washington Adventist	$219,120,045	$7,442,497	3.40%
Doctors Community	$193,854,072	$6,756,740	3.49%
St. Agnes	$433,986,000	$21,573,282	4.97%
Garrett County Memorial	$46,818,203	$2,792,419	5.96%
Holy Cross Silver Spring	$413,796,889	$31,396,990	7.59%

Source: https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits.

(3) <u>Quality of Care</u>

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.

Staff concludes that Bayview documented compliance with Subparagraphs (a)(i) and (iii) of this standard by providing its license from the Maryland Department of Health which shows good standing in the Medicare and Medicaid programs. (DI #3, Exh.8). It also documented that it is accredited by the Joint Commission and by CARF. (DI #3, Exh. 3, 4, 13).

(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.

Staff notes that Paragraph (b) of this standard has become outdated as currently written. There is still a Maryland Hospital Performance Evaluation Guide (HPEG) which is posted as a guide for consumers on the Commission website and includes a set of quality measures.

However, in the decade since this standard was adopted, HPEG has been substantially expanded to include many more measures of hospital quality and performance. However, the specific format of the quality measures component of the HPEG no longer aligns with the format of this standard. Instead of showing the compliance percentage for each of these quality measures, they are now rated comparatively, i.e., "Below Average," "Average," or "Better than Average." Given the new format, staff's practice in administering this standard has been to request the applicant to identify any *below average* rating and discuss its approach to making improvements.

Accordingly, Bayview stated that the Hospital Quality Measures showed its performance as *better than average* for 19 of the measures, *average* for 23 of the measures, and *below average* for 22 of the measures. Bayview provided a list of the *below average* ratings accompanied by the interventions it has made. In Table III-2 below, Commission staff has grouped the individual measures into categories and summarized Bayview's improvement activities.

Table III-2: Bayview Quality Indicators That Rated "Below Average" and Bayview's Improvement Plans

Indicator	Intervention
COPD (readmissions)*	Added Nurse Coordinator, and Community Health Worker to Chronic Obstructive Pulmonary Disease (COPD) clinic, reserving urgent appointment slots in clinic, making better ER observations of COPD exacerbation, creating COPD Nurse transition guide to the community, grant participation in respiratory therapy sessions and peer-led focus groups
Consumer Ratings	• Improve physician communication by implementing a "train the trainer" program • Improve communication about medications by adding stickers/cards to teach patients • Information dissemination about recovery at home will begin using a needs assessment to improve patient education and engagement • Environmental services training in cleaning bathrooms, cleanliness rounds implemented • Pain control patient comments provided monthly to leadership • Lean Sigma Kaizen completed around noise level outside patient rooms with good result

Emergency Department	• Implementation of touchdown space for physicians and care coordinators to improve communication • Implemented upfront screening process and stronger intake department • Physician paired with triage RN during peak hours
Flu Prevention	Implemented a nurse driven protocol for vaccination of eligible patients
Heart Failure	Implemented nurse transition guide before discharge, outpatient diuresis clinic, medication delivery before discharge, heart failure protocol in the ED, in-home patient monitoring offered as well as Nurse Practitioner visits, community health worker added to the clinic and redesigned educational programs for patients and families
Imaging	Radiology will collaborate with the ED to reduce unnecessary imaging orders
Patient Safety	• Readmissions for COPD, heart failure and substance dependency will benefit from improved communication, coordination, increased staffing in the ED and inpatient areas, consultant and medication availability • Implementation of Venous Thromboembolism Committee to screen for appropriate orders and prophylactics
Stroke	Bayview is a tertiary stroke center and treats catastrophic cases, risk adjusted mortality threshold was met
Surgical Patient Safety	Deaths from cardiac/respiratory arrest, pneumonia, sepsis, gastrointestinal bleed or Venous Thromboembolism are usually present on admission not hospital acquired
Healthcare Associated Infections	Methicillin resistant staphylococcus aureus infection challenge with burn unit on campus accounting for 1/3 of cases, decolonizing cases through screenings and extensive cleaning

Source: DI #3, Exh.14.

* Staff notes that the applicant provided its scores on these measures as of June 2017; since that time Bayview's quality scores regarding COPD, flu prevention, and heart failure had improved to "average."

Staff concludes that Bayview has met the requirements of the Quality standard.

COMAR 10.24.10.04B – Project Review Standards

Most of the Project Review Standards found in the Acute Hospital Services Chapter are not applicable in this review. In addition, some standards duplicate others set out in the Acute Inpatient Rehabilitation Services Chapter, at COMAR 10.24.09.04B.[2] These are standards 6, 7, 12, and 13, which address the burden of proof regarding need, the construction cost of hospital space, patient safety, and project financial feasibility. Only applicable and non-duplicative standards from COMAR 10.24.10 are discussed in this Staff Report.

(5) <u>Cost-Effectiveness</u>

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

[2] 10.24.09.04B, Project Review Standards, provides as follows:

> In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, the two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project sites located within a Priority Funding Area.

Paragraph (b) is the only part of this standard that applies, as the applicant is proposing a project involving limited objectives. The applicant refers reviewers to its response to 10.24.01.08G(3)(c), the general criterion addressing the availability of more cost-effective alternatives,[3] in which Bayview explains that the primary objective of this project is to bring its rehabilitation bed license into alignment with its current use of beds. To achieve this, it proposes to convert 16 beds currently licensed as special hospital-chronic care beds to special hospital-rehabilitation beds, resulting in a total of 28 rehabilitation beds, all of which are CARF-accredited. At COMAR10.24.01.08G(3)(c),[4] however, the applicant discusses alternative approaches to meeting this goal.

Staff concludes that the proposed project is the most cost-effective alternative that the applicant could have devised to meet the inconsistency between licensure and operational capacity that the project seeks to address.

[3] See discussion, *infra*, at p.22
[4] See discussion, *infra*, at p.22

(10) Rate Reduction Agreement

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Bayview states that it is not subject to a rate reduction agreement with HSCRC. The applicant notes that it entered into a Global Budget Revenue agreement with HSCRC in 2014 that renews every year unless cancelled by one of the parties. (DI #3, p.58). Bayview explains that it anticipates that it will receive a 50 percent revenue increase on the rehabilitation volume despite a 100 percent volume growth, which will result in a reduction of charges over the projection period and improve savings to Medicare. (DI #3, p.58).

Staff concludes that Bayview has met the requirements of this standard.

(11) Efficiency

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

The applicant proposes to convert 16 licensed chronic care beds to special hospital-rehabilitation beds. As noted, it is already using these licensed chronic care beds as rehabilitation beds. Thus, no change in operation of the facility is implied by this project.

Staff concludes that the applicant has demonstrated why it cannot achieve improvements in operational efficiency by the license status changes that will result from this project.

COMAR 10.24.09 — State Health Plan for Facilities and Services: Specialized Health Care Services – Acute Inpatient Rehabilitation Services

10.24.09.04 Standards.

A. General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this

policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

Please see the discussion of a similar requirement in the Hospital Services Chapter's charity care standard, COMAR 10.24.10.04A(2)(a)(i), *supra*, p. 4.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

Please see the discussion of similar provisions in the charity care standard in the Hospital Services Chapter at COMAR 10.24.10.04A(2)(a)(ii), *supra*, p.4

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

Bayview's policy provides adjustments to charges based on the patient's household income. The scale, based on household income, is as follows:

- Up to 200% of federal poverty guideline (FPL): 100% discount of charges
- Above 200% of FPL and up to 250% of FPL: 75% discount of charges
- Above 250% of FPL and up to 300% of FPL: 50% discount of charges
- Above 300% of FPL and up to 400% of FPL: 35% discount of charges

Staff concludes that Bayview complies with Subparagraph (ii) of the standard.

(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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Please see the discussion of a similar provision in the Hospital Services Chapter's charity care standard at COMAR 10.24.10.04A(2)(b), *supra* p.4

(c) ***A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:***

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

The applicant has demonstrated a commitment to providing charitable hospitalization services to indigent patients based on Hopkins' charity care policy, as evidenced by Bayview's rank within the highest quartile of general hospitals in Maryland for provision of charity care.

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

Bayview already ranks in the top quartile of general hospitals for provision of charity care. Staff conclude that the standard on charity care has been met.

(2) Quality of Care.

A provider of acute inpatient rehabilitation services 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 Commission for Accreditation of Rehabilitation Facilities.

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

Bayview documented compliance with all parts of this standard. (DI#3, Exh. 3, 4, and 8).

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

Bayview provided information on the following quality measures: Functional Independence Measure (FIM), Average Length of Stay (ALOS), Patient Disposition, Central Line Associated Blood Stream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI), Hand Hygiene, Falls, and Pressure Ulcers. See following tables.

Table III-3: Bayview Quality Measures Compared to State Benchmark- 2018

Measure	State Benchmark	Bayview
FIM Improvement from Admission to Discharge* (change in FIM score from admission to discharge)	22	24
FIM Efficiency (# of patient score points gained per patient-day)	2.1	2.3
ALOS*	14 days	13 days
Disposition – Discharge to Acute Care*	11%	11%
Disposition – Discharge to Home or Assisted Living*	63%	65%

Table III-4: Bayview Quality Measures Compared to National Benchmark- 2018

Measure	National Benchmark	Bayview
Infection in Urinary Tract compared to number of expected infections****	0.831	0.429
Falls per 1,000 patient days **	5.18	8.06
Pressure Ulcers***	1.83	0

Sources: *DI #3, Exh.5; **DI #3, Exh.6; ***DI #3, Exh.8; ****www.hospitalsafetygrade.org/

These measures showed:

- In FY2018 the FIM efficiency and improvement scores for Bayview's patients were slightly better than those for Maryland overall;
- ALOS was shorter (one day) than the Maryland average;
- On discharge disposition: (a) a slightly higher proportion of Bayview patients were discharged to home or assisted living than the overall proportion for Maryland. The proportion of Bayview patients discharged to an acute care hospital was the same as the State average. (DI #3, p. 26).

The data shows that, regarding its rate of patient falls, the applicant underperformed other rehabilitation hospitals in the State as a whole. The applicant provided data that showed a spike in the incidence of falls among rehabilitation patients to 17.84 per 1,000 patient days in 2017. Bayview reports that it implemented a performance improvement project to reduce falls in October of 2017. The applicant states that it found the root cause of the rise in incidence of falls was inconsistent application of falls prevention during toileting and transfers. In order to identify patients at high risk for a fall associated with those activities, hospital staff implemented an admission screening for cognition and impulsivity as well as a daily falls audit tool to improve monitoring. The applicant reports it also implemented more patient/family education and safety measures such as alarms and 1:1 sitters. (DI #12, p.4).

Since the time of the performance improvement implementation, Bayview reports that the rate of falls had declined from 17.84 in 2017 to an incidence rate of 8.06 in the first quarter of 2018. (DI #3, Exh.6). Upon staff's request, the applicant provided recent data through the second quarter of 2019 to show continuous improvement. The incidence of falls has declined to a rate of 4.32 which is below (lower numbers are better for this measure) the average state and national benchmark rate. (DI #29, p.1).

Staff concludes that the applicant meets the quality standard.

B. Project Review Standards

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

This standard does not apply, as the applicant is not seeking to justify the need for this project on the basis of barriers to access.

(2) Need.

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

This application would add 16 acute rehabilitation beds to the inventory of the Central Health Planning region, two more than the Commission's most recently published maximum net need estimate for the region. Staff notes that the need projection is based on occupancy standards providing a range of net bed need for each health planning region (HPR) in the State. Bayview falls within the central region, which shows a net need projection range of -36 beds to a deficit of 14 beds, as shown in Table III-5.

Table III-5: Gross and Net Bed Need Projections for Acute Rehabilitation Beds
Central Maryland Region, Target Year 2021

Minimum Avg. Annual Bed Occupancy Standard	Range	Projected Patient Days	Licensed Bed Capacity	Available Bed Days	Gross Bed Need Range	Net Bed Need Range
77%	minimum	62,848	260	94,900	224	(36)
77%	maximum	76,994	260	94,900	274	14

Source: Gross and Net 2021 Bed Need Projections for Acute Rehabilitation Beds by Health Planning Region, by MHCC, published in the Maryland Register, April 13, 2018.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

This paragraph of the standard is not applicable because Bayview does not seek to justify its expansion of licensed rehabilitation beds on need generated by a contiguous HPR or patterns of cross-migration.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

Bayview states that assumptions about migration patterns between Maryland HPRs and bordering states are not applicable to this project, which only seeks to bring the licensed bed complement into alignment with current utilization which reflects volume shifts that have already occurred. (DI #12, p.11).

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

Bayview states that its application does not address barriers to care, essentially because it "has addressed what would be barriers to access by serving patients needing rehabilitation services in chronic beds," and it is seeking "to bring its licensed bed complement into alignment with its current utilization." It also states that "[w]ithout this conversion, if JHBMC were to stop using chronic beds for rehabilitation services, patients would experience significant disruption in and barriers to access." (DI #12, p.10).

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation

services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

Bayview states that this subparagraph does not apply because its projection of need is based on patients currently being served in its rehabilitation program. Thus, inherently, only patients with specialty needs that can be met at Bayview and patients who have already chosen the facility for rehabilitation services are reflected in its current and forecasted volume of service. (DI #12, p.10).

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

Bayview states that migration patterns between Maryland HPRs and bordering states are not a factor in this proposal, as it simply seeks to bring its licensed bed compliment into alignment with its current utilization, reflecting volume shifts that have already occurred. (DI#12, p.10).

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

This paragraph of the standard does not apply since Bayview has not proposed new programs. It does not seek to add a specialized program for pediatric patients and currently specializes in the rehabilitation of patients with brain and spinal cord injuries.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

Paragraph (f) is not applicable. Bayview does not propose dual licensure of beds despite its recent history of using chronic care beds as rehabilitation beds.

<u>Staff Conclusions with respect to the Need Standard</u>

Given the fact that Bayview seeks to add 16 rehabilitation beds to the inventory of the Central Health Planning region, in which the maximum estimated net need by 2021 is only 14, the burden to prove the need for 16 beds is on the applicant.

Bayview has stated that the need to realign its mix of chronic and rehabilitation beds was driven by a shift in the venue of practice of the JHSOM faculty from MedStar Good Samaritan Hospital to Bayview. Commission staff reviewed discharge data and confirmed that, indeed, between FY2016 and FY2019, Bayview's rehab discharges grew from 323 to 705; during the same time period, Good Samaritan's discharges decreased from 1,295 to 1,000. See Table III-6. Bayview has stated that there would likely be barriers to access if it had not taken the action it did to utilize chronic care beds for this purpose.

Table III-6: Rehab Discharges for Bayview and Good Samaritan, FY2016 – FY2019

Hospital	FY2016	FY2017	FY2018	FY2019
Bayview	323	529	730	705
Good Samaritan	1,295	1,230	1,073	1,000

Source: MHCC staff analysis of HSCRC discharge abstract data and JHBMC CY 2016 data submitted directly to MHCC staff in October 2017.

Staff concludes that Bayview's actual utilization of rehabilitation beds demonstrates its need for the beds and recommends that the Commission find that Bayview has met this standard.

(3) Impact.

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

The applicant states the proposed project will not result in a change in service volume, ALOS, or case mix at other acute inpatient rehabilitation providers, nor will the project result in a reduction of availability or accessibility to rehabilitation services, including access for patients who are indigent, uninsured, or those eligible for charity care. As noted in the above discussion of the need standard, Bayview states that its use of chronic care beds for rehabilitation patients occurred because service volume has already shifted from MedStar Good Samaritan to Bayview, following a change in venue for affiliated physicians. Similarly, the applicant states the proposed project will not cause a reduction in the quality of care of other providers, nor affect their ability to maintain the specialized staff necessary to provide acute inpatient rehabilitation services. (DI#3, p. 32).

The applicant has shown that, since it is already operating the complement of rehabilitation beds it has applied for, there is no change to the status quo that would result in any of the changes or impacts identified in this standard. For this reason staff concludes that the applicant complies with this standard.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

This standard does not apply as there are no construction costs associated with this project.

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

This standard does not apply as there is no construction, renovation, or design changes taking place as a result of this project.

(6) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital CON application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii)Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

In response to the above provisions, Bayview provided a complete set of assumptions and stated that its utilization projections are based on its historical market share applied to its service area utilization rate and population. (DI #3, Exh. 18). In the table below, the applicant shows how

utilization of acute rehabilitation beds changed beginning in FY2017. It expects this shift in utilization to continue.

Table III-7: Actual/Projected Patient Days FY2016-2025 Rehabilitation and Chronic Care

	Actual		Projected							
Fiscal Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
Rehabilitation	5,740	8,234	9,365	9,365	9,365	9,365	9,365	9,365	9,365	9,365
Chronic Care	14,311	11,681	9,028	9,028	9,028	9,028	9,028	9,028	9,028	9,028

Source: DI #12, p.21.

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

Bayview's submission of actual and projected revenues and expenses shows positive operating results.

Table III-8: Bayview Fiscal Year Uninflated Revenue and Expense ($000s)

	Actual		Projected					
Fiscal Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Net Operating Revenue	$605,677	$610,284	$631,789	$627,888	$626,580	$625,471	$624,735	$649,722
Expense	$585,448	$599,688	$621,789	$608,207	$609,308	$610,678	$612,489	$641,228
Non-Operating Income	($14,011)	($7,320)	($10,030)	($15,977)	($5,344)	($1,235)	$2,888	$5,942
Net Income	$6,218	$3,276	($30)	$3,704	$11,928	$13,558	$15,134	$14,436

Source: DI #3, Exh.17.

Staff recommends that the Commission find that the applicant has met each part of this standard and that the project is financially feasible.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

The proposed inpatient rehabilitation unit will contain 28 beds. Its actual utilization (while already operating 28 beds) was 80.6 percent in FY2017, and its "current year, projected" occupancy at the time of the application's submission was 91.6 percent. This compares favorably to the Minimum Occupancy Standard prescribed in the Acute Rehabilitation Services Chapter, which, for units of 0-49 beds is 75%. Staff concludes that the application meets this paragraph of the standard.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

This paragraph of the standard is not applicable because the project does not involve establishment of a new rehabilitation hospital.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

The applicant notes that Bayview's rehabilitation facilities are already licensed by the State and accredited by CARF. Its policy, entitled *Transfer of a Patient to Another Hospital*, states that transfer of a patient with needs exceeding Bayview's capabilities only occurs if the receiving facility has the available space and qualified personnel to provide for the patient's treatment requirements. (DI #3, Exh.9).

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

The policy referenced in Paragraph (a) immediately above also describes scenarios in which a transfer may be needed for reasons other than lack of space or needing a level of service that exceeds Bayview's capabilities. Possible transfers may result from a patient's use of a physician without privileges at Bayview, a patient's being insured by an insurer that is not accepted by the hospital, or a patient's electing a transfer to seek alternative treatment. (*Id*.). The policy provides that the patient must be able to be transferred without harm to a facility that has space and that the facility has agreed to accept the patient. (*Id.*).

Staff has reviewed Bayview's policy on transfers provided and concludes that the Transfer and Referral Agreement standard has been satisfied.

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system as a whole.

This is not a comparative review.

B. COMAR 10.24.01.08G(3)(b) – NEED

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

There is an applicable need analysis. See discussion at COMAR 10.24.09.04B(2), *supra*, p. 15. Staff concluded that Bayview justified an addition of licensed rehabilitation beds that would slightly exceed the Commission's projected maximum bed need. The proposed project would realign Bayview's mix of chronic and rehabilitation beds to match actual demand for these types of beds. The applicant has credibly posited that patients would have experienced barriers to access at Bayview, where, presumably, the patients' physicians then practiced, if it had not taken the action it did to utilize chronic beds for this purpose.

Staff recommends that the Commission find that Bayview has demonstrated a need for the proposed project.

C. COMAR 10.24.01.08G(3)(c) – AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Primary Goals and Objectives of the Project

Bayview states that the primary objective of this project is to bring its licensed rehabilitation bed inventory into alignment with its current census of rehabilitation patients. To achieve this, it proposes simply to convert 16 licensed chronic care beds to rehabilitation beds, which would result in a total of 28 rehabilitation beds, all of which are already CARF-accredited.

Analysis of Alternatives

Bayview identified and analyzed two alternatives.

One alternative would be for Bayview to discontinue providing rehabilitation services in the chronic care beds, leaving just 12 rehabilitation beds available for admissions. The second alternative would be to discontinue providing rehabilitation services in the 16 beds licensed as chronic care beds and develop alternative rehabilitation bed capacity at another location within the Johns Hopkins Health System.

Bayview points out that, in FY2018, the 28 beds it uses for rehabilitation patients experienced 732 discharges with an ALOS of 12.8 days and operated at an average annual occupancy rate of 91.6 percent. Bayview states that if it had used only 12 rehabilitation beds (as per the first alternative) and used them similarly, it would have accommodated just 314 rehabilitation patients, suggesting a need to turn away 418 patients. In addition, Bayview would see a decrease in revenue from rehabilitation services, and the rehabilitation staff training programs

in place at Bayview would accommodate fewer trainees, potentially jeopardizing the long-term viability of the program. (DI #3, p.67).

The second option, discontinuing use of 16 chronic care beds for rehabilitation patients and developing alternative space to expand the program, would result in a temporary loss of capacity and revenue until a new location was identified and developed. This alternative would involve a capital expenditure. (DI #3, p. 68).

Bayview states that this comparative analysis shows that its chosen alternative is the most cost effective alternative, as it involves no capital expenditure and no service disruption or revenue loss. It accommodates patient preferences in what Bayview describes as a shift in market demand from another Baltimore provider of rehabilitation hospital services to Bayview, which was caused by a shift in clinicians' practice locations.

Staff concludes that the applicant has chosen the most cost effective approach to accommodating the shift in demand for rehabilitation hospital services.

D. COMAR 10.24.01.08G(3)(d) – VIABILITY OF THE PROPOSAL

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Availability of Resources to Implement the Proposed Project

The applicant states that there are no construction or renovation expenditures associated with the proposed project. (DI #3, p. 77).

Availability of Resources to Sustain the Proposed Project

The applicant provided consolidated financial statements for The Johns Hopkins Health System Corporation and Affiliates (June 30, 2017 and 2016) that showed a healthy excess of assets over liabilities.

Bayview provided a revenue and expense schedule that shows a positive margin from operations in FY2016 and FY2017 and very modest revenues over expenses. It projected a deficit of revenues over expenses in FY2018 and a return to more healthy revenue over expense margins by FY2021. Audited financial statements for Johns Hopkins Health System Corporation[5] show that Bayview generated income from operations in both FY2018 ($8.4 million) and FY2019 ($7.9 million) but had a deficit of revenues over expenses before non-controlling interests (-$788,000) in FY2019.

[5] https://hscrc.maryland.gov/Documents/Hospitals/ReportsFinancial/Audited/FY-2019/JHHS_FY2019_AFS.pdf

Table III-9: Bayview Revenues, Expenses, and Income
Actual FY2016-2017 and Projected FY2018-2023, Uninflated ($000s)

	Actual		Projected					
Fiscal Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Net Operating Revenue	$605,677	$610,284	$631,789	$627,888	$626,580	$625,471	$624,735	$649,722
Expense	$585,448	$599,688	$621,789	$608,207	$609,308	$610,678	$612,489	$641,228
Non-Operating Income	($14,011)	($7,320)	($10,030)	($15,977)	($5,344)	($1,235)	$2,888	$5,942
Net Income	$6,218	$3,276	$(30)	$3,704	$11,928	$13,558	$15,134	$14,436

Source: DI#3, Exh.17.

Staff recommends that the Commission find that Bayview will be viable if it implements this project.

E. COMAR 10.24.01.08G(3)(e) – COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

The applicant provided the following list of CONs issued to Bayview since 1983:

- Bayview was a co-applicant with JHH to relocate 18 rehabilitation beds from Good Samaritan Hospital to the Johns Hopkins Health System. (Docket #96-24-1983, approved on April 8, 1997).
- Bayview was awarded a CON to expand its general purpose operating room capacity from 10 to 14 rooms, increase the capacity of its post-anesthesia care unit, and construct a new air handling infrastructure. (Docket # 05-24-2165, approved November 22, 2005).
- Bayview was awarded a CON to construct an annex building next to its Emergency Department to house: an expanded adult emergency department and a new Psychiatric Evaluation Services Unit; a 13-space all private room adult observation and holding unit; and a combined pediatric inpatient, emergency, and observation/holding unit. (Docket # 11-24-2321, approved February 16, 2012).
- Bayview was awarded a CON for capital expenditures associated with the creation of a comprehensive cancer program including the construction of two linear accelerator vaults and the equipping of one vault. (Docket # 11-24-2322, approved February 16, 2012).
- A CON for a joint venture by Bayview and Genesis Bayview JV Holdings, a subsidiary of Genesis HealthCare, was awarded to establish a new 132-bed comprehensive care facility on the Bayview campus. On January 2, 2014, the applicant notified the Commission that it would not proceed with this project and would relinquish the CON (Docket #11-24-2323, approved March 12, 2012).

(DI #3, pp. 72-73).

Staff concludes that the applicant has demonstrated compliance with all terms and conditions of previous Certificates of Need.

F. COMAR 10.24.01.08G(3)(f) – IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Bayview maintains that the project will not have an impact on the volume of service provided by any other existing provider of rehabilitation hospital services. It states that the project will not affect the service area population's access to health care services. The applicant also believes that the project will not have an impact on costs to the health care delivery system because it is only proposing to align the licensure classification of its rehabilitation and chronic beds with its actual use of those beds. Bayview explains that it expects its referrals to come from the same sources that have historically referred patients to Bayview, and assumes that there will be no further shifts in market share beyond those that gave rise to this project. (DI #3, p.74).

Staff concludes that the impact of this project is acceptable. Aligning the licensure status of the beds with their actual use will bring the hospital into compliance with State law and improve the ability to correctly interpret hospital utilization data sets.

IV. SUMMARY OF RECOMMENDATION

Based on its review and analysis of the Certificate of Need application, staff recommends that the Commission find that the proposed project complies with the applicable State Health Plan standards and general CON review criteria. Staff notes that the project brings the hospital's licensed bed capacity in line with a market shift that has already occurred and that Bayview accommodated without making the required regulatory compliance steps prior to the accommodation.

For these reasons, staff recommends that the Commission **APPROVE** a 16-bed increase in Bayview's licensed complement of licensed acute rehabilitation beds and a 16-bed reduction in Bayview's licensed complement of chronic care hospital beds.

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

*** ***

FINAL ORDER

Based on the analysis and conclusions in the Staff Report and Recommendation, it is this 20th day of February, 2020:

ORDERED, that the application of Johns Hopkins Bayview Medical Center, Inc. for a Certificate of Need to add 16 special rehabilitation hospital beds, currently licensed as special chronic care hospital beds, and to reduce its inventory of licensed special chronic care hospital beds by 16 beds is **APPROVED**, with no capital expenditure, renovations, or construction.

MARYLAND HEALTH CARE COMMISISON

APPENDIX 1

RECORD OF THE REVIEW

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	Letter of Intent received and acknowledged	7/10/18
2	Revised Letter of Intent received and acknowledged	8/20/18
3	Certificate of Need Application filed	9/7/18
4	Receipt of Certificate of Need application acknowledged	9/12/18
5	Request to publish notice in *Baltimore Sun* by MHCC staff	9/12/18
6	Request to publish notice in *Maryland Register* by MHCC staff	9/12/18
7	Notice published in the *Baltimore Sun*	9/19/18
8	MHCC staff requests completeness information	10/4/18
9	Request for and granting of extension to file response to completeness questions until 11/2/18	10/9/18
10	Additional request for and granting of extension to file response to completeness questions until 11/16/18	11/1/18
11	Additional request for and granting of extension to file response to completeness questions until 12/14/18	11/19/18
12	Bayview submits response to completeness information	1/4/19
13	MHCC staff notifies the applicant of the January 18, 2019 formal start of the review	1/4/19
14	MHCC staff requests publication of the notice of the formal start of the review in Baltimore Sun	1/4/19
15	MHCC staff requests publication of the notice of the formal start of the review in Maryland Register	1/4/19
16	MHCC staff requests local health department comments	1/4/19
17	MHCC staff requests HSCRC comments on the project	1/14/19
18	Notice of formal start of the review published in the Baltimore Sun	1/24/19
19	Interested Party comments received from United Workers Organization, Charm City Land Trust and Sanctuary Streets (Commenters)	2/14/19
20	Deadline was given for response to Commenters	2/22/19
21	Bayview submitted a response to Commenters	3/11/19
22	The Commenters submitted a response to the Bayview response	3/25/19
23	Communication regarding provisions of copies of comments to the applicant	4/1/19

24	The applicant makes a motion to strike a reply filing by the Commenters	4/3/19
25	The applicant responds to comments	4/11/19
26	The Commenters make a reply to Bayview's response	5/6/19
27	Bayview motion to strike Commenters filing on May 6, 2019	5/17/19
28	Bayview responds to Commenters filing	5/22/19
29	Email exchange between Kevin McDonald and Spencer Wildonger resulting in Bayview submission of updated data on quality measures	8/5/19
30	Sabonis to Steffen – Commenters' answer to Bayview's motion to strike comments	8/20/19
31	Harting to Potter – Applicant's Opposition to Motion to Extend Deadline for IP Comments	9/3/19
32	Entrance of Appearance for United Workers by Leonard L. Lucchi and Stephanie P. Anderson	10/9/19
33	Email exchange between Suellen Widman, AAG, and Stephanie P. Anderson, Esquire, regarding Entrance of Appearance; Leonard L. Lucchi and Stephanie P. Anderson represent only United Workers and Charm City Land Trust	11/25/19-12/02/19
34	Metz to Commenters/Harting – Appointment of Reviewer and denial of requests for Interested Party status in the review	12/19/19
35	McDonald to Langley – project status conference summary	1/29/20
36	Bayview submitted a revised Financial Assistance Policy	1/29/20