

Bon Secours Baltimore Health System 2010 Community Benefit Narrative

#1 Licensed Bed Designation and Inpatient Admissions

Bon Secours Hospital (“BSB” or the “Hospital”) is a 126 bed facility with 7,488 admissions for the fiscal year ended August 31, 2010.

#2 Description of the Community Served

BSB exists to benefit the people living in West Baltimore, where nearly one-third of the city's total population resides. Dominated by the elderly, women and children, BSB's service area includes stable, thriving neighborhoods as well as many neighborhoods facing basic social challenges in the areas of housing, employment, education and health. BSB's service area is a predominately (83%) African-American community.

BSB's service area is primarily lower income families with an annual average per capita income of \$9,508 and unemployment of 21%. Seniors over 65 years of age comprise 14% of the population and 37% of the children under the age of 18 live in poverty. Sixty four percent of the patients that BSB serves are malnourished at the time of admission, which is twice the national average. Approximately 41% of BSB's admission's are either Self- Pay or Medicaid patients.

#3, #4, #5, #7 Identification of Community Needs, Decision Making Process & Evaluation of Effectiveness

The main focus of the community efforts by Bon Secours Hospital is the immediate area around the Hospital's campus. Represented by Operation Reach Out Southwest (“OROSW”), this area contains a community of approximately 21,000 persons containing 13 distinct neighborhoods surrounding Bon Secours Hospital. Although the community is located in close proximity to the hospital it meets the federal guidelines of a medically underserved population. Not surprisingly, the residents of these neighborhoods have some of the worst indicators of poor health status in the State. Our residents have some of the highest rates in the State for childhood diseases, breast and cervical cancer, poor nutrition, cardiovascular disease and diabetes. The community has been challenged by a host of social and economic ills including, vacant housing, high unemployment, illicit drug activity and drug related crime.

Bon Secours approach to needs assessment is a collaborative one. Bon Secours works very closely with OROSW to develop, implement and monitor community benefit programs. OROSW, in partnership with Bon Secours, has developed and is implementing a 20 year revitalization plan in which Bon Secours has and will continue to serve as an anchor of stability and hope.

Decision making ultimately rests with the BSB board. The board works closely with the Executive Leadership Team of Bon Secours Hospital, the Executive Director of the Bon Secours Foundation, the Bon Secours Foundation board and the national Bon Secours Health System, Inc. (“BSHSI”) board to insure the most effective use of the resources available. Ongoing needs assessment is done by Foundation staff and OROSW.

With participation from over 200 residents and local stakeholders, BSB and OROSW completed a comprehensive revitalization plan in 1998. This plan includes a vision statement and desired outcomes and strategies in each of six issue areas: economic development, education, health, physical planning, public safety, and enriching activities for youth and seniors. Programs have been launched and many positive outcomes have been achieved in each of these areas, including:

- 559 units of affordable housing for the elderly;
- Over 400 people placed in jobs through the OROSW Career Development Program;
- More than 200 graduates of the OROSW Youth Employment and Entrepreneurship Program;
- Establishment of Our Money Place, a community-based financial service center at which over 1,100 West Baltimore residents have opened accounts;
- Over 1,000 families served through the Bon Secours Family Support Center; and
- 600+ vacant lots transformed into green space through our Clean & Green Program.

Much of the coalition's work has moved from a planning and implementation focus to one of managing programs and services. The Coalition's current leadership has aged and there is an effort underway to engage younger community residents into leadership roles. A major challenge is maintaining participation and related momentum at all levels (coalition, neighborhood, and block). This is critical because much remains to be done and we have learned that the most successful initiatives are resident led and community driven.

Through the OROSW coalition, we have set up a decision making infrastructure that ensures meaningful resident participation in *planning and implementation*. We have also learned that success is more certain when you reverse thinking from addressing deficits in the community to building upon assets. We have also learned that success is more likely when we implement strategies and initiatives that are consistent with the communities' plans *and* appropriate to our organizational resources and skills.

Although the original 20 year vision and plan remain as our overarching "roadmap", we periodically engage in specific engagement projects in order to assess current levels of community needs. Most recently we held a Health Care Community Discussion as part of the Obama-Biden Transition effort in late December 2008 and are continuing this effort in partnership with OROSW and several community service providers. The coalition steering committee has identified three committees (Crime & Grime, Housing & Physical Planning, and Health) that are meeting to identify priority issues/projects to present to the broader coalition membership in early 2010. In November 2009, we launched a community health engagement process in partnership with OROSW and with assistance from the University of Maryland at Baltimore Social Work Community Outreach Service who are providing the staff organizing and outreach aspects of the process. The goal of this project is to engage the community around the hospital in a process that should culminate with:

- an agreed-upon *vision* of an improved healthcare system which leads to a healthier community *and* is financially sustainable
- a *plan* to achieve our vision

This planning process is nearly complete and has resulted in recommendations and strategies under three major areas of focus: Healthy People, Healthy Environment and Healthy Economy.

6 Major Community Benefit Program Initiatives

"Community Benefit" is not just a program within BSB, but rather a constitutive dimension of its mission and history. From its beginnings in 1881 providing healthcare and support in neighbors' homes, to the establishment of its first hospital in 1919, to its comprehensive neighborhood revitalization initiative in the 21st Century – BSB has been an integral part of the community life of West Baltimore.

Community Based Clinical Services

BSB community-based clinical services include the Community Institute of Behavioral Services which provides a variety of clinical and community based behavioral health services; the Imani Center which provides primary and specialty care to persons affected by HIV/AIDS; health screenings at no charge at various sites throughout the community; and free transportation to and from medical appointments for the elderly and disabled. These programs served over 120,000 persons during FY 10.

Health Care Support Services

Tele-Heart is a disease management program for persons diagnosed with congestive heart failure and hypertension that served almost 4,800 persons in FY 10.

Community Benefit Operations/Financial and In-Kind Contributions

The Bon Secours of Maryland Foundation provides oversight and administration of BSB Community Benefit operations as well as contributions to local community groups.

Community Building is a strategic initiative of BSB. This initiative encompasses long term, collaborative relationships in which service organizations engage and empower the members of a defined geographic community to support them in improving their quality of life and holistic health.

Since 1995, BSB has worked closely with the Operation ReachOut Southwest (OROSW) community to create projects, programs and work plans that are leading to the realization of OROSW's vision: to make southwest Baltimore a community of choice for current and new residents.

Over the past few years, OROSW and BSB have collaborated to make tremendous strides in building programs and projects that are improving the quality of life for the residents of southwest Baltimore. The improvements have been accomplished by building off the strengths of the community, listening and responding to what residents say is needed, and hiring talented people to implement the projects.

Our Money Place (OMP) – combines the services of the Security Plus Federal Credit Union, a local check casher, OROSW and BSB. Since opening in 2003, OMP has offered savings accounts, market rate loans, low cost check cashing, debt remediation free and low-cost tax preparation and retirement planning to help residents reduce non-asset building debt and increase personal wealth. Over 2,100 persons utilized these services in FY 10.

Youth Employment and Entrepreneurship Program (YEEP) helps high school age youth learn job readiness, financial literacy and leadership skills and then access part time and summer jobs. YEEP also helps youth develop career plans and get into post-secondary education. The program follows alumni who attend college. Over 350 area youth participated in YEEP activities in FY 10.

Clean & Green turns vacant lots into attractive green spaces and consistently maintains them at a community-wide scale. The program maintained over 450 lots in FY 10.

Career Development Program offers job readiness, placement and retention services where, after a four-week intensive classroom experience, clients are followed for three years and helped to move up the company ladder, obtain more education as needed, get out of debt and learn basic money management skills. The ultimate goal is for a person to obtain financial self-sufficiency. A total of 91 individuals completed our job readiness training and 140 community residents were placed in employment in FY 2010. We also screened 536 individuals for public benefits with 121 individuals receiving benefits.

Family Support Center helps young parents obtain a GED and get into college while providing developmental childcare and parenting classes. Children (birth to age 4) receive developmental childcare while their parents are in class or in training. In addition, the Family Support Center staff provides In-Home-Intervention services. Nine hundred fifty-five parents and children were served during FY 10.

Women's Resource Center is a drop-in center that provides crisis intervention, hospitality services and domestic violence counseling for homeless women or women at risk for becoming homeless. Over 660 women were served in FY 10.

Housing BSB also renovates row houses and constructs apartment buildings where low-income families and seniors can find safe and affordable housing in what had been dangerous, abandoned and drug-ridden properties. Over 550 families and seniors were housed in FY 10.

#8 Gaps in Availability of Specialist Providers

Across the country, the vast majority of specialist providers rely upon reimbursement from Medicare, Medicaid, Managed Care, and patients to provide financial support for their practices. However, for hospitals such as Bon Secours that serve low income, urban poor areas, the opportunities for specialist to be compensated through these vehicles are extremely low. Consequently, if these specialist providers were to attempt to provide the needed health care services for these hospitals, through only the support of paying patients, they would be quickly forced to close their practices or move to a community with a far more favorable payor mix.

For a hospital like Bon Secours to continue to support the community with the varied specialist providers necessary for a full – service medical /surgical hospital with Emergency and Surgical Services, some manner of support is required to ensure the provision of this professional specialized medical care. With approximately 41% of the patient population presenting as Charity, Self Pay and Medicaid, specialist physicians serving patients at Bon Secours are simply unable to cover their cost.

In particular, the primary shortages in availability, absent some form of financial support, come in the form of ED, ICU, Surgical, regular physician staffing, in addition to the “on call” coverage necessary to support 24 hour services in these areas. As a result, in Bon Secours’ fiscal year 2009 Annual Filing, the “Part B “ support provided by the hospital as indicated in the “UR6” Schedule totals \$14.8 million. The fiscal year 2010 Annual Filing has not been completed at this time, however FY 10 “UR6” Schedule totals are anticipated to be comparable to FY 09. To a hospital the size of Bon Secours, this is a significant outlay of support that is necessary to provide the specialist care required to compassionately and equitable care for our patients.

Therefore, real and significant “gaps” in the availability of specialist providers in this community exist, which currently is only being filled via support from the hospital. These gaps are currently being filled in the following specialist areas:

- ED Coverage (approx. \$2.8 million)

- Anesthesia (approx. \$1.6 million)
- Medical/ Surgical “House Coverage” (approximately \$1.2 million)
- OR on-call coverage (approximately \$1.0 million)
- Intensive Care (approx. \$0.8 million)
- Psychiatry (approximately \$0.6 million)
- Radiology (approximately \$0.6 million)
- Other Specialties, including Laboratory, Vascular, Hemodialysis and Pathology

In addition to these gaps that are currently filled via subsidy, relatively unmet specialist needs for both the uninsured and insured within our facility include ENT Specialist, limited G.I. (Gastrointestinal Specialist), Neurologist, Urologist and Endocrinologist.

Appendix 1

Bon Secours Baltimore Health System

Description of Charity Care Policies

Bon Secours Baltimore Health System (BSBHS) is committed to ensuring access to health care services for all. As a health care provider, BSBHS treats all patients, whether insured, underinsured or uninsured, with dignity, respect and compassion throughout admission, delivery of services, discharge and billing and collection processes. BSBHS addresses the needs of the uninsured by providing free or reduced fees on hospital services, community outreach efforts to assist with Medicaid and SCHIP enrollment, and free community-based preventive and primary care services.

BSBHS proactively screens to identify individuals and their families who may qualify for federal, state or local health insurance programs or the Bon Secours Patient Financial Assistance Program (“FAP”). Potentially eligible patients are referred to the Patient Financial Assistance Department for assistance in completing the documentation required to establish eligibility in, and apply for, government insurance programs or the FAP. Patients are responsible for providing the information necessary to complete the documentation.

The FAP aids uninsured patients who do not qualify for government-sponsored health insurance and who communicate their inability to pay for their medical care. The FAP provides 100% financial assistance to uninsured patients with annual family incomes at or below 200% of the Federal Poverty Guidelines (“FPG”), as adjusted by the Medicare geographic wage index for each community served to reflect that community’s relative cost of living (“Adjusted FPG”).

For uninsured and underinsured patients with annual family incomes greater than 200% of the Adjusted FPG, the FAP offers a reduction to the amount of the full charges for medically necessary services through a community service adjustment (“CSA”). The CSA is market adjusted and based on the payment discount received by other health care payers doing business in the community. For these patients, the FAP also sets a maximum annual family payment liability to ensure that no family suffers a catastrophic financial burden to receive necessary health care services. Based on research conducted by the Tax Foundation, the maximum annual family liability is based on a sliding scale determined by the family income and size. The standard sliding scale is adjusted by the Medicare geographic wage index of each community served to reflect that community’s relative cost of living. All patients are eligible for a Prompt Pay Discount. In addition, a variety of other potential payment options are available. This patient financial assistance policy is communicated to patients verbally upon registration and through visible postings of the policy and brochures in common areas throughout the hospital.

BSBHS is required to adhere to the system-wide Patient Financial Assistance/Charity Care Policies. These policies have been attached for your information and use (“Appendix 2”).

These policies and procedures are communicated and made available to patients in a wide variety of ways:

- At each point of registration, there are signs advising patients that Bon Secours has financial assistance available if they are unable to pay their bills. In addition, brochures are given to patients summarizing the policy, along with the financial assistance application.
- At time of discharge, patients are identified who may demonstrate a lack of coverage. For those patients, assistance is provided in conjunction with a Social Worker to have the appropriate physician complete a medical disability form (402 B), as appropriate. This information is then provided to the outside firm DECO, who assists Bon Secours patients with applying for and securing enrollment in the State Medicaid program.
- In each billing letter, Bon Secours has language that advises patients that, if paying their balance in full is not possible, to please call our toll-free Customer Service Center. At that time, Bon Secours' extended payment plan will be explained to them, as well as the patient Financial Assistance Program, as noted above.

**Bon Secours Health System, Inc.
System-Wide Policy Manual**

TOPIC: Patient Financial Assistance Services **POLICY NO.:** CYC-01 / FAP0025 and E5101 **DATE:** September 1999
REVISED: July 9, 2010

AREA: Patient Financial Services
Patient Financial Assistance **APPROVED BY:** Rich Statuto

PURPOSE

Bon Secours Health System, Inc. ("BSHSI") is committed to ensuring access to needed health care services for all. BSHSI treats all patients, whether insured, underinsured or uninsured, with dignity, respect and compassion throughout the admissions, delivery of services, discharge, and billing and collection processes.

Policy

The Bon Secours Health System ("BSHSI") exists to benefit people in the communities served. Patients and families are treated with dignity, respect and compassion during the furnishing of services and throughout the billing and collection process.

To provide high quality billing and collection services, standard patient financial assistance services and procedures are utilized. These services and procedures address the needs of patients who have limited financial means and are not able to pay in part or in full for the services provided without undue financial hardship (excluding cosmetic or self pay flat rate procedures).

The BSHSI financial assistance policy provides 100% financial assistance to uninsured patients with annual family incomes at or below 200% of the Federal Poverty Guidelines ("FPG"), as adjusted by the Medicare geographic wage index for each community served to reflect that community's relative cost of living ("Adjusted FPG").

Based on research conducted by the Tax Foundation, the maximum annual family liability is based on a sliding scale determined by family income and size. A standard BSHSI sliding scale is adjusted by the Medicare geographic wage index of each community served to reflect that community's relative cost of living.

Procedures

The standard patient financial assistance services and procedures are organized as follows.

Procedure	Policy Section
Communication and Education of Services	• 1
Preliminary Determination of Insurance and Financial Status	• 2
Financial Counseling	• 3
Prompt Pay Discounts	• 4
Billing and Letter Series	• 5
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Program Enrollment Assistance	• 7
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Definitions

- Charity – “the cost of free or discounted health and health related services provided to individuals who meet certain financial (and insurance coverage) criteria” as defined the Catholic Health Association of the United States.
- Income – The total family household income includes, but is not limited to earnings, unemployment compensation, Social Security, Veteran’s Benefits, Supplemental Security Income, public assistance, pension or retirement income, alimony, child support and other miscellaneous sources.
- Bad Debt – An account balance owed by a patient or guarantor that can afford to pay, but has refused to pay, which is written off as non-collectable.
- Baseline – 200% of the Federal Poverty Guidelines (“FPG”) – utilized by all BSHSI Local Systems to determine eligibility for the Patient Financial Assistance Program.
- Medical Eligibility Vendor/Medical Assistance Advocacy - Advocacy vendor contracted by BSHSI to screen patients for government programs and BSHSI Financial Assistance.
- Patient Financial Assistance Program – A program designed to reduce the patient balance owed provided to patients who are uninsured and underinsured and for whom payment in full or in part of the financial obligation would cause undue financial hardship.
- Prompt Pay Discount – A discount on the patient balance owed if paid within thirty (30) days of billing.
- The Tax Foundation Special Report – Guidelines for calculating the patient balanced owed for individuals participating in the Patient Financial Assistance Program, which identifies the percent income set aside for savings and medical expenses. The source is “A Special Report from the Tax Foundation”; dated November 2003, document number 125.
- Community Service Adjustment (“CSA”) – A reduction in total charges to an account, which reflects an offset to the cost of healthcare to our uninsured patients and families.
- Uninsured – Patients who do not have any insurance and are not eligible for federal, state or local health insurance programs.
- Local System Champion (“LSC”) – The individual appointed by the Local System CEO to assist in the education of staff and monitor compliance with this policy.

- Head of Household ("Guarantor") – The individual listed on tax return as "Head of Household". This will be the individual used for tracking Family Annual Liability.
- Household Family Members ("Dependents") – Individuals "residing" in household which are claimed on the tax return of the Head of Household (Guarantor).

Communication and Education of Services

POLICY NO. CYC-01/FAP_0025 Section 1

- 1.1 All BSHSI representatives that have contact with patients regarding financial status are responsible for advising patients of the BSHSI Patient Financial Assistance Services Program.
- 1.2 Standard signs and brochures are prepared by BSHSI Patient Financial Services for limited customization (name and logo) by each Local System. Signs and brochures are available in English and Spanish. Each Local System is responsible for having the signs and brochures translated into the other dominant languages spoken in the respective community in a manner that is consistent with the English version.
- 1.3 A brochure and education on its content are provided to each patient upon registration. Signs and brochures are predominantly displayed in patient registration, customer service, waiting and ancillary service areas.
- 1.4 Brochures and education on the content are provided to physicians and their staff.
- 1.5 Changes to the brochure or signs are prepared by BSHSI Patient Financial Services and distributed to each Local System Director of Patient Financial Service for immediate use. All brochures must be approved by BSHSI Patient Financial Services and reviewed for Medicare and Medicaid compliance.
- 1.6 The LSC is responsible to ensure that all community service agencies are provided information regarding the BSHSI Patient Financial Services practices. It is recommended that this be done in a forum that is interactive.
- 1.7 Training, education and resources on the Patient Financial Assistance Services Policy and Procedures is provided to each Local System CEO, VP of Mission, Director of Patient Financial Services and the Local System Champion and staff, as needed, to ensure consistency in deployment and policy administration.
- 1.8 Accommodations will be made for non-English speaking patients.

Preliminary Determination of Insurance and Financial Status

POLICY NO. CYC-01/FAP_0025 Section 2

- 2.1 The Patient Access Staff, including Registration and Medical Eligibility Vendor/Medical Assistance Advocacy, screen all patients to identify individuals and their families who may qualify for federal, state or local health insurance programs or the Patient Financial Assistance Program (see section 8 of this Policy). Potentially eligible patients are referred to Patient Financial Services for financial counseling.

- 2.2 Although proof of income is requested for consideration of the Patient Financial Assistance Program some Local System DSH regulations may require proof of income. Such regulations will be handled on a case-by-case basis.
- 2.3 Automatic charity assessment and credit checks for accounts greater than \$5,000 will be considered.

Financial Counseling	POLICY No. CYC-01/FAP_0025 Section 3
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- 3.1 Patient Financial Services Staff, including the Patient Access Staff, is responsible for assisting patients and their families in determining eligibility and applying for federal, state and local insurance programs and/or for the Patient Financial Assistance Program. If applicable, referral for debt counseling is made. Information will be made available at all patient access locations, including 24-hour emergency departments.
- 3.2 A standard financial information worksheet is used to collect and document the patient's insurance and financial status. The standard worksheet is reviewed as needed, but at least annually, by the BSHSI Director of Patient Financial Services. Any changes to the standard work sheet are communicated to each Local System Director of Patient Financial Services and Local System Champion for immediate use.
- 3.3 Patient cooperation is necessary for determination. If patient does not provide the financial information needed to determine eligibility for the Patient Financial Assistance Program, the patient will be given the opportunity for a Prompt Pay Discount.
- 3.4 All uninsured patients are provided a Community Service Adjustment, at the time of billing.
- 3.5 All BSHSI locations will have dedicated staff to assist patients in understanding charity and financial assistance policies.

Prompt Pay Discounts	POLICY No. CYC-01/FAP_0025 Section 4
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- 4.1 All patients are eligible for a 10% Prompt Pay Discount when the patient balance owed is paid in full within thirty (30) days of the bill date. Patient is responsible for deducting the 10% prompt pay discount at the time of payment.
- 4.2 The Local System Director of Patient Financial Services is responsible for ensuring compliance with all state laws and regulations regarding discounts for health care services.

Billing and Letter Series	POLICY No. CYC-01/FAP_0025 Section 5
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- 5.1 A standard letter series is used to inform the patient of the patient balance owed and the availability of the Patient Financial Assistance Program. (See BSHSI Patient Financial Services Policy No C1217.)
- 5.2 The BSHSI Director of Patient Financial Services or designee reviews as needed, but at a minimum on an annual basis, the standard letter series. Any changes to the standard letter series are communicated to each Local System Director of Patient Financial Service or designee and Local System Champion for immediate use.

- 5.3 A distinct letter series is used for the Patient Financial Assistance Program to inform the patient of eligibility status and the patient balance owed. (See BSHSI Patient Financial Services Policy No. C313.)
- 5.4 The BSHSI Director of Patient Financial Services or designee reviews as needed, but at a minimum on an annual basis, the distinct letter series for Patient Financial Assistance Program. Any changes to the distinct letter series are communicated to each Local System Director of Patient Financial Service or designee and Local System Champion for immediate use.
- 5.5 It is the policy of BSHSI to provide notification to a patient at least thirty (30) days before an account is sent to collection. Written notice can be included with the bill.

Payment Options	POLICY NO. CYC-01/FAP_0025 Section 6
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- 6.1 A variety of payment options are available to all patients and their families.
- **Monthly Pay Plan** - Patient pays the patient balance owed over an eight-month period with a minimum monthly payment of \$50. In the State of New York, the monthly payment shall not exceed ten percent (10%) of the gross monthly income of the patient. A patient may receive a monthly payment due reminder or choose an automatic check debit or credit card payment method.
 - **Loan Program** - Assistance in obtaining a low-cost retail installment loan with an independent finance company is provided if the patient is not able to pay the patient balance owed within eight months of the billing date.
 - **Single Payment** – Patients may choose to wait to pay the patient balance owed until after their insurance company has paid its portion. The patient balance owed is due within thirty (30) days of the billing date.
- 6.2 The Patient Financial Services staff documents the payment option selected by the patient in the financial information system.
- 6.3 Payments will be applied in the following order, unless otherwise directed by the LS DPFS:
- In accordance with remittance advice or EOB
 - As directed by the patient/guarantor

In the absence of the above two points:

- The most current account

This approach mitigates issues with the handling of Family Annual Liability and reduces expense to the organization.

- 7.1 The Medical Eligibility Vendor/Medical Assistance Advocacy screens referred patients for eligibility for the following programs (this list is not inclusive of all available programs):
 - SSI Disability / Federal Medicaid
 - State Medicaid
 - Local/County Medical Assistance Programs
 - State-Funded Charity Programs
 - BSHSI Patient Financial Assistance Program
- 7.2 The Medical Eligibility Vendor/Medical Assistance Advocacy assists the patient in completing and filing application forms for all programs for which the patient may be eligible, including the BSHSI Patient Financial Assistance Program.
- 7.3 The Medical Eligibility Vendor/Medical Assistance Advocacy forwards the completed Patient Financial Assistance Program application form (and any documentation) to Patient Financial Services for processing.
- 7.4 Patients should be encouraged to apply for financial assistance as soon as possible, and in the State of New York, Patients will have at least ninety (90) days from date of discharge or date of service to apply for financial assistance and at least twenty (20) days to submit the completed application (including any state or federally required documentation)
- 7.5 Certain government programs may require proof of income.
- 7.6 Patients without US citizenship presenting as uninsured will be eligible for the CSA however they must also be screened for available programs and/or referred to an international case firm (as determined by the Local System).
- 7.7 Insured patients without US citizenship must be referred to an international case firm (as determined by the Local System) for processing.

- 8.1 The Patient Financial Assistance Program assists uninsured and underinsured patients who are not able to pay in part or in full the account balance not covered by their private or government insurance plans without undue financial hardship.
- 8.2 The standard minimum income level to qualify for 100% charity through the Patient Financial Assistance Program is an income equal to or less than 200% of the Federal Poverty Guidelines. BSHSI will not include Patient's assets in the application process.
- 8.3 Individuals above the 200% of the Federal Poverty Guidelines can be found eligible for partial assistance. Determination of a patient's maximum annual liability considers the patient's income and size. The patient balance owed is calculated using the formula illustrated in the Tables below.

- 8.4 In Maryland, individuals between 200% and 300% of the federal poverty guidelines may qualify for partial financial assistance based on the BSHSI reduced scale. Individuals above 300% may also qualify for partial financial assistance based on the BSHSI reduced scale.
- 8.5 In New York, when a patient is above 200% but less than or equal to 250% of the Federal Poverty Guidelines, the hospital shall apply a graduated scale not to exceed the maximum that Medicare, Medicaid, the charge from a third party payor, or the charge from the BSHSI hospital as adjusted by the CSA, whichever is more generous.
- 8.6 In New York, when a patient is equal to or above 251% of the Federal Poverty Guidelines, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by Medicare, Medicaid, or the "highest volume payor, or the charge from the BSHSI hospital as adjusted by the CSA, whichever is more generous.

UNINSURED ONLY:

Note: This Table Does Not Address New York Patients.

Step I	$[\text{Charges}] \times [\text{Community Service Adjustment}] = \text{Adjusted Account Balance Owed}$ <p><u>Uninsured patients ONLY</u> will receive an "account" balance reduction / Community Service Adjustment (CSA). The reduction is market adjusted and will insure that patient's will never pay 100% of charges. The patient is still fully responsible for their Annual Liability after FAP (Steps II & III below).</p> <p>NOTES: The Community Service Adjustment applies to the balance due on individual accounts.</p> <ul style="list-style-type: none"> a) If patient is approved for financial assistance they are responsible for each adjusted account balance owed amount until they meet their annual family liability. b) If patient is not approved for financial assistance, they are responsible for each adjusted account balance owed without an annual threshold.
Step II	$[\text{Household Income}] - [\text{Federal Poverty Guidelines, Adjusted for Family Size}] = \text{Adjusted Household Income}$
Step III	$[\text{Adjusted Household Income}] \times [\text{The Tax Foundation \% which identifies the amount of Household Income Spent for Medical Expenses}] = \text{Patient/Family Maximum Annual Liability}$ <p><u>Once the annual liability is met any balances thereafter will be processed as 100% charity (see section 8.6).</u></p>
Step IV	$\text{As applicable, } [\text{Patient Balance Owed}] - [10\% \text{ Prompt Pay Discount}] = \text{Discounted Patient Balance Owed.}$
Step V	$\text{As patients become eligible for FAP the CSA will be reversed and processed as a charity adjustment.}$

UNDERINSURED ONLY:

Note: This Table Does Not Address New York Patients.

Step I	[Household Income] – [Federal Poverty Guidelines, Adjusted for Family Size] = Adjusted Household Income
Step II	[Adjusted Household Income] x [The Tax Foundation % which identifies the amount of Household Income Spent for Medical Expenses] = Patient/Family Maximum Annual Liability <u>Once the annual liability is met any balances thereafter will be processed as 100% charity (see section 8.6).</u>
Step III	As applicable, [Patient Balance Owed] - [10% Prompt Pay Discount] = Discounted Patient Balance Owed
Step IV	As patients become eligible for FAP the CSA will be reversed and processed as a charity adjustment.

- 8.7 The BSHSI Director of Patient Financial Services prepares and distributes updates to the Federal Poverty Guidelines, The Tax Foundation Average % and the respective Local System Cost of Service Adjustment as a part of the annual Strategic Quality Plan and Budget Guidelines process. The Local System Champion is responsible to ensure Guidelines are followed.
- 8.8 Patient Financial Services determines and documents the patient's eligibility for the Patient Financial Assistance Program and notifies the patient. The letter of approval/denial is mailed to the patient after receipt of the application and supporting documentation.
- 8.9 Patients determined to be eligible for Patient Financial Assistance Program retain eligibility for a period of twelve (12) months from the date of approval. At the end of those twelve (12) months, the patient is responsible for reapplying for eligibility for the Patient Financial Assistance Program.
- 8.10 Services provided as a result of an accident are subject to all legal instruments required to ensure third party liability payment, even if these instruments are filed after the initial eligibility for the Patient Financial Assistance Program has been approved. If third party coverage exists, BSHSI will collect the balance owed from the third party payer.
- 8.11 Application can be made on behalf of the patient by the following parties, including but not limited to:
 - Patient or guarantor
 - Faith community leader or representative
 - Physician or other health care professionals
 - Member of the Administration

8.9 Validated denial of coverage will be considered as uninsured and will be provided CSA.

Pursuit of Non-Payment	Policy No. CYC-01/FAP_0025 Section 9
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- 9.1 No collection efforts are pursued on any pending Patient Financial Assistance Program account.
- 9.2 Any collection attorneys working on behalf of BSHSI are NOT authorized to attach bank accounts and in no case file body attachments. BSHSI collection attorneys follow BSHSI's value-based procedures in the pursuit of estates, garnishments and judgments for non-payment of debts. In no event will BSHSI ever put a lien on a patient / guarantor's primary residence.
- 9.3 In New York, BSHSI payment plans will not contain an accelerator or similar clause under which a higher rate of interest is triggered by a missed payment.
- 9.4 Each Local System uses a reputable collections attorney for the processing of legal accounts.
- 9.5 The Local System Director of Patient Financial Services is responsible for reviewing balances of \$5,000 and greater to confirm that all appropriate actions have been taken prior to the patient balance being written off to Bad Debt or sent for suit. Policy allows for the Local Systems to be more stringent in their practices with respect to authorization levels.
- 9.6 As State requirements permit, deceased patients with no estate or patients that have been discharged through a Chapter 7 bankruptcy are automatically qualified for 100% charity write off.
- 9.7 All collection-type vendors are required to comply with the BSHSI Code of Conduct.

Accountability and Monitoring	Policy No. CYC-01/FAP_0025 Section 10
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- 10.1 Reports on the program status are issued monthly, as part of current patient financial services/ revenue cycle reporting, to each Local System CEO, CFO, VP of Mission, Director of Patient Financial Services, Local System Champion and staff and others as defined.
- 10.2 The indicators used to monitor the program are:
 - Main Indicators:
 - Bad Debt as % of Gross Revenue
 - Charity Care as % of Gross Revenue
 - Monitoring Indicator:
 - Reduction to % of accounts/dollars in bad debt that have been reclassified to charity.
- 10.3 The Local System CEO is the responsible person to insure applicable standardization of implementation and compliance with the integrity of the program on an ongoing basis.

11.1 Due to the ever-changing environment and current proposed legislation it will be necessary to revise this policy as appropriate.

11.2 It may be necessary to address certain State requirements within this policy to insure compliance with applicable laws and regulations.

11.3 Maryland State Only Regulations

- The Maryland HSCRC (Health Service Cost Review Commission) requires all Maryland hospitals to use the Uniform Financial Assistance Application form beginning January 1, 2006.
- To maintain compliance with applicable Maryland laws, Bon Secours Maryland will not sell bad debt accounts to any third parties. Bon Secours may use third party vendors to assist in the collection of bad debt and charity accounts.
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11.4 New York State Only Requirements:

- Appeals Process for Re-Consideration of a Denied Application – All patients that have been denied have the right to appeal by contacting the New York business office at 800-474-3900. .
- The following are the reporting requirements by the hospital:
 - A report on hospital costs incurred and uncollected amounts in providing services to the uninsured and under insured, including uncollected co insurance and deductible amounts.
 - The number of patients, organized by zip code, who applied for financial assistance, and the number of patients by zip code whose applications were approved and whose applications were denied.
 - The amount reimbursement received from the Hospital Indigent Care Pool.
 - The amount spent from charitable funds, trusts or bequests established for the purpose of providing financial assistance to eligible patients as defined by such trusts or bequests.
 - If local social services district in which the hospital is located permits the hospital to assist patients with Medicaid applications, the number of Medicaid applications the hospital helped patients complete, and the number approved and denied.
 - The hospital's losses resulting from providing services under Medicaid.

Prepared by/Title: Nick Dawson, Director Revenue Cycle Services

Signature/Date: _____

Reviewed by/Title: Joe Ingold, VP Integration, Revenue Cycle Services

Signature/Date: Jed 7/17/10

Approved by/Title: Joe Ingold, VP Integration, Revenue Cycle Services

Signature/Date: Jed 7/12/10

Related Policies & Procedures; Notes; Controls:

Revision Date:
(Use if Revised.)

Review Date:
(Use if Reviewed
No Changes.)

Nick Dawson	Additions for New York State	April 18, 2008
Nick Dawson	Additions for Maryland State	April 24, 2008
Nick Dawson	Inclusions of board approved language	June 4 th 2008
Nick Dawson	Addition of section 8.4 for Maryland HSCRC regulations	January 6 2010
Nick Dawson	Revised section 8.8 extending patient approval letter to 60 days	April 20 2010
Nick Dawson		July 9 2010

Filename: BC

E5101

Date: September, 1999

Appendix 3

Description of Mission, Vision and Values

While in many ways the Mission of Bon Secours speaks for itself, an outside observer would benefit from the knowledge that the Mission is driven by and sustained through the Eight Core Values of the system. They are Respect, Justice, Integrity, Stewardship, Innovation, Compassion, Quality, and Growth.

It is part of the culture of Bon Secours to live these values on a day to day basis. They drive the System's desire to treat patients in a holistic way, by treating mind, body, and spirit.

Our community benefits programs reflect the System's desire to help the people of West Baltimore attain and maintain good health by helping in the areas of housing, career development, and health awareness.

It is through the values of Respect and Justice that we strive to provide adequate housing. It is because of the values of Integrity and Stewardship that we seek to use the resources available in the most effective manner. Compassion and Quality compel us to treat all patients in a caring way. And Innovation and Growth drives our desire to continue to serve the community for many years into the future.

Appendix #4

BON SECOURS BALTIMORE HEALTH SYSTEM

MISSION

The Mission of the Bon Secours Baltimore Health System is to help people and communities to health and wholeness by providing compassionate, quality health care and being ***good help*** to all in need in West Baltimore, with special concern for the poor and dying, in response to the Gospel mandate and healing ministry of Jesus Christ and the Catholic Church.

VISION

By the year 2010, the Bon Secours Baltimore Health System will be recognized as a health care leader. Our healing ministry will be expressed through services to the West Baltimore community that include focused acute and ambulatory care, community outreach, and health education programs that are focused, innovative, financially sustainable and in collaboration with others. Quality and compassionate care will continue to be our hallmark.

VALUES

At the heart of the Mission and Vision of Bon Secours Baltimore Health System are these eight **CORE VALUES:**

RESPECT--We treat all people well because all people have dignity.

JUSTICE--We support, protect and promote the rights of all individuals and we have a special concern for the rights of the poor and the dying.

INTEGRITY--We are honest in our dealings and our behavior is consistent with our thoughts, feelings and actions.

STEWARDSHIP--We are dedicated to the responsible and creative utilization of our resources to assure the continuance of our mission.

INNOVATION--We continually search within ourselves and our partnerships for new ways to profoundly improve our services and life in the surrounding communities.

COMPASSION--We experience and express empathy with the life situations of others.

QUALITY--Quality is continually improving our system's processes of care and service to our patients, physicians, co-workers and community through understanding their needs and striving to exceed their expectations.

GROWTH--We are committed to the implementation of programs that inspire positive development in the organization, our co-workers and our community. We are sensitive to the changes necessary to meet this challenge.