BWMC FY10 COMMUNITY BENEFIT REPORT

1. Baltimore Washington Medical Center is a 321 licensed bed facility with 20,767 inpatient admissions in FY10.

2. Anne Arundel County is compact but diverse, including within its borders the state's capital and its largest airport, 534 miles of coastline, and long strips of farmland and other sparsely populated territory. More than 500,000 residents call Anne Arundel County home.

   BWMC Primary Service Area

Zip Code	City
21060	Glen Burnie
21061	Glen Burnie
21122	Pasadena
21144	Severn
21225	Brooklyn Park
21226	Curtis Bay

   BWMC South Service Area

Zip Code	City
21012	Arnold
21032	Crownsville
21054	Gambrills
21108	Millersville
21114	Crofton
21401	Annapolis
21402	Annapolis
21146	Severna Park

   BWMC West Service Area

Zip Code	City
21090	Linthicum
21113	Odenton
20755	Ft. Meade
21240	BWI
21227	Elkridge/Arbutus
21076	Hanover

Demographic Characteristics (2008 Estimates)

Total Population	512,790
Median Household Income	$83,285
Individuals below poverty level	4.1%
Families below poverty level	2.3%

Data Source: American Community Survey, U.S. Census Bureau; Maryland State Data Center, Maryland Department of Planning.

	Life Expectancy (Years)
White	79.7
Black	75.4
All Races	78.6

Data Source: Division of Health Statistics, Maryland Department of Health and Mental Hygiene.

In FY10, there were 166,041 patient registrations at Baltimore Washington Medical Center. Of these registrations, 27,102 or 16.3% were uninsured.

3. Baltimore Washington Medical Center utilizes the Anne Arundel County Department of Health Report Card of Community Health Indicators to direct community outreach activities each year. This report card is issued by the Anne Arundel County Department of Health and reviewed by BWMC each year. The April 2009 Report Card was utilized to direct FY10 community outreach efforts.

   BWMC maintains a strong relationship with the Anne Arundel County Department of Health, meeting on a regular basis to review and discuss various community health programs and initiatives Additionally, ongoing work in the community and with community organizations, including participation on committees and advisory councils, allows for continuous communication and often provides new ideas and opportunities for BWMC to maximize community outreach efforts.

4. The Anne Arundel County Department of Health Report Card of Community Health Indicators allows BWMC to research, develop and implement programs that are beneficial to the community. The major community needs identified in the May 2010 report card were cancer, heart disease, stroke, chronic lower respiratory diseases (CLRD), and infant mortality.

5. To ensure that the community's most pressing health care issues are addressed, BWMC's executive leaders and community outreach staff reviews the Anne Arundel County Department of Health Report Card of Community Health Indicators annually and determines which community needs will be addressed through community benefit activities each year.

6. Cancer

Cancer is the leading cause of death in Anne Arundel County with incidence and mortality rates of lung, colorectal, breast and prostate at or above the state average. In an effort to encourage early detection, Baltimore Washington Medical Center offers cancer screenings (i.e. prostate) to the community each year. Monthly cancer support groups for breast and prostate cancer are also offered. Informative talks on cancer prevention, early detection, treatment options, etc. are offered each year at a variety of locations throughout the community. Smoking cessation classes are also offered. See chronic lower respiratory diseases (CLRD) for more information. BWMC works with area churches and community groups to disseminate information about cancer screenings and events to better reach at risk populations.

Heart Disease/Day of Dance

Day of Dance is an annual event held each February in recognition of National Heart Month to celebrate the benefits of dance and exercise in the prevention of heart disease. Participants have the opportunity to try various dance styles, enjoy dance demonstrations and participate in free health screenings such as cholesterol, blood pressure and body mass index. Educational information on heart disease, cancer and diabetes is also available. This wellness event is widely promoted and well attended by all ages of community members.

BWMC also offers several informative heart healthy talks each year and blood pressure screenings each month at various locations in the community.

Stroke

As a Primary Stroke Center, BWMC offers a monthly stroke support group that serves as a resource for patients who are recovering from a stroke or who are at high risk for having a stroke. Additionally, informative talks on stroke prevention are offered each year at a variety of locations throughout the community.

The Maryland Vascular Center at BWMC offers free monthly vascular screenings to the community. These potentially life-saving screenings for carotid artery disease, abdominal aortic aneurysms and peripheral arterial disease are offered to community members age 50 or older who have one of the following risk factors: hypertension, diabetes, family history of vascular disease, high cholesterol or who smokes.

Results are made immediately available to participants and for abnormal results where follow-up is indicated, a clinician from The Maryland Vascular Center calls the participant’s primary physician to discuss the findings.

Chronic Lower Respiratory Diseases (CLRD)

Many chronic lower respiratory diseases (CLRD) included in this category can be linked to tobacco use. Baltimore Washington Medical Center receives grant funding from the Anne Arundel County Department of Health to offer free tobacco cessation counseling classes and nicotine replacement aids to a limited number of adults 18 and older who live, work or attend school in Anne Arundel County. In FY10, BWMC offered two sessions of tobacco cessation classes (sessions are seven weeks each), serving a total of 20 people. Five of the 20 participants (25%) had discontinued their use of tobacco by the end of the session. With room for improvement, this percentage is consistent with the quit rate of similar programs in Anne Arundel County.

Infant Mortality

Prenatal care is essential to increasing chances of positive pregnancy outcomes. BWMC's Stork's Nest is an incentive-based prenatal education program to encourage pregnant women to have a healthy pregnancy, giving their babies the best opportunity for a healthy beginning. Participants receive points for each class they attend, as well as physician visits and healthy behaviors. Participants can then use those points to purchase baby items, including infant clothing, strollers, car seats, diapers, feeding supplies, portable cribs and first aid supplies.

Women can continue to earn points after their babies are born by taking them to well baby check-ups and making sure they receive immunizations on time. Participants can use the points until their babies are one year old. Any pregnant woman in Anne Arundel County is eligible to participate in Stork's Nest, but the program's emphasis is on engaging pregnant women who do not receive regular prenatal care and are at an elevated risk for having a low birth weight or premature birth – potential causes of infant mortality.

Stork's Nest has experienced significant growth from 2006 to 2010. Originally, one six-week hour-long class was held at BWMC's Arundel Mills Outreach Center. The program now offers multiple eight-week, hour long education classes at the Pascal Women's Center at Baltimore Washington Medical Center. One Spanish class, two adult English classes, and one teenage class are available. In FY07, the program began with 44 participants. This number increased to 57 participants in FY08, and 150 participants in FY09. In FY10, 180 women attended Stork's Nest. The number of participants for FY11 is expected to reach 200.

The steady growth of the program is due to the Stork's Nest coordinator, who is responsible for direct oversight of the program and outreach to potential participants, physicians and potential referral sources. The coordinator develops relationships with churches, community centers, public schools and clinics to educate potential referrers about the program and provide contact information.

7. Program Evaluation

1a. Name of initiative: Stork's Nest
1b. Year of evaluation: FY10 (ongoing)
1c. Nature of evaluation: Comprehensive demographic data is captured on each program participant to ensure the program is serving the target population. Additionally, three-month (obtained earlier if the participant contacts the program coordinator) and 12-month phone calls (based on participants' due date) are made to program participants. Infant birth data is obtained and participants are asked a set of questions based on the information presented in the classes (i.e. the proper safe sleeping environment for baby). If indicated, the program coordinator uses this as an opportunity to re-teach concepts. Participants are also asked to rate their satisfaction with the overall program. BWMC utilizes feedback and comments to continually improve Stork's Nest.

1d. Result of evaluation: The program coordinator was unsuccessful in reaching 36% of program participants (with due dates on or before 6/30/10) to obtain infant data. Several findings are summarized in the table below:

Enrolled in WIC (Women, Infants and Children)	76%
Attended Eight Classes	49%
Births by Gestational Age (at or >35 weeks)	97%
Baby Birth Weight (at or > 6 lbs.)	87%
Baby Birth Weight (at or > 5 lbs.)	96%
Overall satisfaction with program (satisfied or very satisfied)	100%

2a. Name of initiative: Prostate Screening Follow-Up
2b. Year of evaluation: 2010 (June)
2c. Nature of evaluation: Prostate results from both the PSA blood test and the digital exam (DRE) are reviewed by the screening physicians. Follow-up letters are mailed to all screening participants. This letter contains screening results and if indicated, a recommendation to follow-up with a physician. Additionally, all abnormal screenings are followed-up with a phone call from BWMC's outreach coordinator. During this call, the coordinator verifies that the participant received and understands the screening results. The outreach coordinator is also able to link the participant with an appropriate physician if the participant has not already selected one. The coordinator also follows up by phone 6-8 weeks later to determine if the participant is receiving appropriate care.

Additionally, overall screening results are collated and trended by BWMC's outreach coordinator.

2d. Result of evaluation: 98 men participated in the prostate screenings offered by BWMC. It was determined that 19 men had abnormal findings (abnormal PSA, DRE or both). This represents approximately 19.4% of participants. Attempts were made to contact the 19 men - the outreach coordinator was successful in reaching 11 participants (five participants did not return our calls and three participants were not reachable at the phone number on-file). Nineteen participants have or will receive two follow-up phone calls from the outreach coordinator during the 12 month post-screening period.

8. While Anne Arundel County is generally not considered underserved, there is a significant portion of the population surrounding BWMC that houses an underserved, uninsured and indigent population.

   Baltimore Washington Medical Center does offer a financial assistance program to serve those patients who are treated at the medical center, uninsured and do not qualify for any federal or state assistance programs (Medicaid, REACH, etc).

   BWMC continues to maintain a relationship with People's Community Health Centers. People's operates two health centers in BWMC's service area, one located in Brooklyn Park and the other in Severn. They provide high-quality, comprehensive medical, dental, and neonatal health care to all, regardless of the ability to pay or insurance status.

   BWMC does not currently have any gaps in availability of specialist providers to serve the uninsured cared for by the hospital.

Appendix 1

Baltimore Washington Medical Center's Financial Assistance Policy is established to assist patients in obtaining financial aid when it is beyond their ability to pay for services rendered.

A patient's inability to obtain financial assistance does not, in any way, preclude the patient's right to receive and have access to medical treatment at Baltimore Washington Medical Center.

Baltimore Washington Medical Center informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state or local government programs or under the hospital's financial assistance policy in the following manner:

- BWMC posts its financial assistance policy and financial assistance contact information in all admission areas, the emergency room and all other outpatient areas throughout the facility.
- BWMC discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and employs dedicated staff on-site to assist patients with qualification for such programs.
- A copy of BWMC's financial assistance policy is included in the patient handbook that is provided to each patient upon admission.
- An abbreviated statement referencing BWMC's financial assistance policy, including a phone number to call for more information, is run annually in the local newspapers (*Maryland Gazette* and *Capital*).

Appendix 2

Financial Assistance Policy

POLICY

Baltimore Washington Medical Center (BWMC) strives to be the health system of choice through excellence in service, including service to residents of the community who do not have the adequate financial resources to pay for necessary health care service. Baltimore Washington Medical Center will grant financial assistance to patients who have the **demonstrated inability to pay**. The hospital's ability to grant financial assistance is dependent on the patient's complete, honest, and prompt cooperation with the financial assistance application process, as well as the availability of hospital resources to cover the cost of financial assistance.

1. All patients shall be eligible for financial assistance provided they meet the necessary criteria.

2. Financial assistance will be given without regard to age, race, creed or sex.

3. Application for charity care should be made as soon as possible in the admissions process; however, an application may be taken at any time during the billing and collection process. Applications are available at all hospital registration areas or can be obtained by calling the Patient Financial Assistance Customer Service representative at 410-787-4517.

4. Notice of the availability of financial assistance shall be posted in the Admissions Office, the Emergency Department, and points of clinical registration within the hospital. Such notice will be posted in English and Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

5. BWMC will provide the financial assistance application, policies, procedures, and information available in English and Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

6. BWMC will provide financial assistance only for services deemed medically necessary. Financial assistance will not be granted for patients scheduled for elective cosmetic surgery.

7. Patients in the Medicaid Primary Adult Care (PAC) program may be automatically considered for financial assistance at the time of billing.

8. Patients eligible for the Anne Arundel REACH Program are automatically considered for financial assistance at the time of billing.

9. Outpatient emergency services denied as medically unnecessary for patients covered under a Medicaid Managed Care Organization (MCO) may be automatically considered for financial assistance.

10. BWMC will provide financial assistance to individuals in households below 200% of the federal poverty level and reduced cost of care up to 300% of the federal poverty level.

11. Criteria to be considered in determining financial assistance eligibility include, but are not limited to: household income, patient's employment status and capacity for future earnings, other living expenses, and financial obligations.

12. Supporting documentation may include the following:

    a. Copies of pay stubs, unemployment benefits, social security checks, cash assistance checks, alimony or child support checks
    b. Prior year's tax returns
    c. Bank statements
    d. Proof of expenses
    e. Basic Needs letter that indicates how persons with no incomes are meeting their day to day living needs.

    Patients will have 15 calendar days to return financial forms and the necessary documentation. Failure to provide requested documentation may result in denial for financial assistance.

13. BWMC will make every effort to determine financial assistance eligibility within two business days after the submission of the financial assistance application and all requested documentation.

14. A specific amount of financial aid will be established annually in the hospital's operating budget. This amount shall not exceed the maximum limitation for financial assistance as established by the Health Services Cost Review Commission.

15. BWMC reserves the right to modify this Financial Assistance Policy depending on the availability of such financial assistance allowances as established by the Health Services Cost Review Commission or any subsequent governing bodies or by the hospital staff.

ORIGINATOR

Director, Patient Accounting

REVIEW CYCLE

3 Years

APPROVAL

President/Chief Operating Officer

UNIVERSITY OF MARYLAND MEDICAL SYSTEM	The University of Maryland Medical System Policy & Procedure	*Policy #:*	TBD
		Effective Date:	10-01-2010
	Subject:	*Page #:*	1 of 8
	FINANCIAL ASSISTANCE	*Supersedes:*	07-31-2010

1. *POLICY*

a. This policy applies to [Entity Name] ("[Entity Acronym]"). [Entity] is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

b. It is the policy of [ENTITY] to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

c. [ENTITY] will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients receiving inpatient services with their Summary Bill and made available to all patients upon request.

d. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

e. [ENTITY] retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent services, applications to the Financial Assistance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

2. *PROGRAM ELIGIBILITY*

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, [ENTITY] strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further [ENTITY] commitment to our mission to provide healthcare to those residing in the neighborhoods surrounding our hospital, [ENTITY] reserves the right to grant Financial Assistance without formal application being made by our patients. The zip codes for the [ENTITY] primary service area are included in ***Attachment A***. Additionally, patients residing outside of our primary service area may receive Financial Assistance on a one-time basis for a specific episode of care.

b. Specific exclusions to coverage under the Financial Assistance program include the following:

   i) Services provided by healthcare providers not affiliated with [ENTITY] (e.g., home health services)

   ii) Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Assistance Program.

      (1) Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

   iii) Unpaid balances resulting from cosmetic or other non-medically necessary services

   iv) Patient convenience items

   v) Patient meals and lodging

vi) Physician charges related to the date of service are excluded from [ENTITY]'s financial assistance policy. Patient's who wish to pursue financial assistance for physician-related bills must contact the physician directly.

c. Patients may become ineligible for Financial Assistance for the following reasons:

i) Refusal to provide requested documentation or providing incomplete information.

ii) Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to [ENTITY] due to insurance plan restrictions/limits.

iii) Failure to pay co-payments as required by the Financial Assistance Program.

iv) Failure to keep current on existing payment arrangements with [ENTITY].

v) Failure to make appropriate arrangements on past payment obligations owed to [ENTITY] (including those patients who were referred to an outside collection agency for a previous debt).

vi) Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

d. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section 3 below) eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

f. Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follow the sliding scale included in ***Attachment B***.

3. ***PRESUMPTIVE FINANCIAL ASSISTANCE***

a. Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, [ENTITY] reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining Financial Assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only Financial Assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

i) Active Medical Assistance pharmacy coverage

ii) Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums)

iii) Primary Adult Care ("PAC") coverage

iv) Homelessness

v) Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs

vi) Maryland Public Health System Emergency Petition patients

vii) Participation in Women, Infants and Children Programs ("WIC")

viii) Food Stamp eligibility

ix) Eligibility for other state or local assistance programs

x) Patient is deceased with no known estate

xi) Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

b. Patients who present to the Outpatient Emergency Department but are not admitted as inpatients and who reside in the hospitals' primary service area may not need to complete a Financial Assistance Application but may be granted presumptive Financial Assistance based upon the following criteria:

i) Reside in primary service area (address has been verified)

ii) Lacking health insurance coverage

iii) Not enrolled in Medical Assistance for date of service

iv) Indicate an inability to pay for their care

v) Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

c. Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

i) Purely elective procedures (e.g., Cosmetic procedures) are not covered under the program.

ii) Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive Financial Assistance program until the Maryland Medicaid Psych program has been billed.

iii) Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.

4. ***MEDICAL HARDSHIP***

a. Patients falling outside of conventional income or presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program.

i) Uninsured Medical Hardship criteria is State defined:

(1) Combined household income less than 500% of federal poverty guidelines

(2) Having incurred collective family hospital medical debt at [ENTITY] exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.

(3) The medical debt excludes co-payments, co-insurance and deductibles

b. Patient balance after insurance

i) [ENTITY] applies the State established income, medical debt and time frame criteria to patient balance after insurance applications

c. Coverage amounts will be calculated based upon 0 - 500% of income as defined by federal poverty guidelines and follow the sliding scale included in **Attachment B.**

d. If determined eligible, patients and their immediate family are certified for a 12 month period effective with the date on which the reduced cost medically necessary care was initially received

e. Individual patient situation consideration:

   i) [ENTITY] reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

   ii) The eligibility duration and discount amount is patient-situation specific.

   iii) Patient balance after insurance accounts may be eligible for consideration.

   iv) Cases falling into this category require management level review and approval.

f. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, [ENTITY] is to apply the greater of the two discounts.

g. Patient is required to notify [ENTITY] of their potential eligibility for this component of the financial assistance program.

5. ***ASSET CONSIDERATION***

a. Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

b. Under current legislation, the following assets are exempt from consideration:

   i) The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.

   ii) Up to $150,000 in primary residence equity.

   iii) Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6. ***APPEALS***

a. Patients whose financial assistance applications are denied have the option to appeal the decision.

b. Appeals can be initiated verbally or written.

c. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

d. Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.

e. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration

f. The escalation can progress up to the Chief Financial Officer who will render a final decision.

g. A letter of final determination will be submitted to each patient who has formally submitted an appeal.

7. PATIENT REFUND

a. Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration

b. Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

c. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8. JUDGEMENTS

a. If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, [ENTITY] shall seek to vacate the judgment and/or strike the adverse credit information.

9. PROCEDURES

a. Each Service Access area will designate a trained person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Customer Service, etc.

b. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   i) Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.

   ii) Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

   iii) [ENTITY] will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

   iv) Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.

   v) Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

c. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:

   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).

ii. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

iii. Proof of social security income (if applicable)

iv. A Medical Assistance Notice of Determination (if applicable).

v. Proof of U.S. citizenship or lawful permanent residence status (green card).

vi. Reasonable proof of other declared expenses.

vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

d. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on [ENTITY] guidelines.

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

(1) If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.

(2) If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled.

(a) A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

e. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

f. The following may result in the reconsideration of Financial Assistance approval:

i. Post approval discovery of an ability to pay

ii. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to [ENTITY]

g. [ENTITY] will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

h. If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

DEVELOPER

Patient Financial Services Department, [ENTITY]

Reviewed/Revised: 09-28-2010

ATTACHMENT A

The following zip codes represent the coverage areas for the respective Entities:

UMMC / JLK / USH – All zip codes in the state of Maryland are covered under this policy.

BWMC 20755, 21012, 21032, 21054, 21060, 21061, 21076, 21090, 21108, 21113, 21114, 21122, 21144, 21146, 21225, 21226, 21227, 21240, 21401, 21402

CRHC 21607, 21610, 21617, 21619, 21620, 21620, 21623, 21628, 21635, 21638, 21644, 21645, 21650, 21651, 21651, 21656, 21657, 21658, 21661, 21666, 21667, 21668, 21678, 21690

MGH 21225, 21201, 21202, 21205, 21206, 21207, 21211, 21212, 21213, 21215, 21216, 21217, 21218, 21223, 21224, 21228, 21229, 21230, 21239

SHS 21601, 21607, 21609, 21610, 21612, 21613, 21617, 21619, 21620, 21620, 21622, 21623, 21624, 21625, 21626, 21627, 21628, 21629, 21631, 21632, 21634, 21635, 21636, 21638, 21639, 21640, 21641, 21643, 21644, 21645, 21647, 21648, 21649, 21650, 21651, 21651, 21652, 21653, 21654, 21655, 21656, 21657, 21657, 21658, 21659, 21660, 21661, 21662, 21663, 21664, 21665, 21666, 21667, 21668, 21669, 21670, 21671, 21672, 21673, 21675, 21676, 21677, 21678, 21679, 21690, 21835, 21869

ATTACHMENT B

Sliding Scale

		% of Federal Poverty Level Income										
		200%	210%	220%	230%	240%	250%	260%	270%	280-290%	300% - 499%	
Size of Family Unit	FPL Income	Approved % of Financial Assistance										
		100%	90%	80%	70%	60%	50%	40%	30%	20%	25% of Income	
1	$10,830	$21,660	$22,743	$23,826	$24,909	$25,992	$27,075	$28,158	$29,241	$30,324	$32,490	(3) $54,150
2	$14,570	$29,140	$30,597	$32,054	$33,511	$34,968 (2)	$36,425	$37,882	$39,339	$40,796	$43,710	$72,850
3	$18,310	$36,620	$38,451	$40,282	$42,113	$43,944	$45,775	$47,606	$49,437	$51,268	$54,930	$91,550
4	$22,050	$44,100	$46,305	$48,510	$50,715	$52,920	$55,125	$57,330	$59,535	$61,740	$66,150	$110,250
5	$25,790	(1) $51,580	$54,159	$56,738	$59,317	$61,896	$64,475	$67,054	$69,633	$72,212	$77,370	$128,950
6	$29,530	$59,060	$62,013	$64,966	$67,919	$70,872	$73,825	$76,778	$79,731	$82,684	$88,590	$147,650
7	$33,270	$66,540	$69,867	$73,194	$76,521	$79,848	$83,175	$86,502	$89,829	$93,156	$99,810	$166,350
8	$37,010	$74,020	$77,721	$81,422	$85,123	$88,824	$92,525	$96,226	$99,927	$103,628	$111,030	$185,050

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
- Patient earns $53,000 per year - There are 5 people in the patient's family - The % of potential Financial Assistance coverage would equal 90% (they earn more than $51,580 but less than $54,159)	- Patient earns $37,000 per year - There are 2 people in the patient's family - The % of potential Financial Assistance coverage would equal 40% (they earn more than $36,425 but less than $37,882)	- Patient earns $54,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, owed 25% of $54,000 ($13,500)

Notes: FPL = Federal Poverty Levels

Appendix 3

Throughout the past four decades, Baltimore Washington Medical Center has evolved into a comprehensive medical center, offering the highest quality of care to the community. Through hiring and retaining outstanding people, BWMC provides exceptional service to patients and visitors. Highly trained physicians and associates, coupled with state-of-the-art technology, complement treatment capabilities while maintaining a focus on service and quality at every level of the organization.

Appendix 4

VISION STATEMENT

To be the preferred regional medical center through nationally recognized quality, personalized service and outstanding people.

MISSION STATEMENT

The mission of Baltimore Washington Medical Center is to provide the highest quality healthcare services to the communities we serve.