COMMUNITY BENEFIT NARRATIVE REPORT

FY2013

Medstar Southern Maryland Hosp

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) hospital community benefit programs.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes	All Other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:

283	16,535	20735 20748 20744 20747 20772 20746 20745 20602	Civista Medical Center, Doctors Community Hospital, Anne Arundel Medical Center, Calvert Memorial Hospital, Fort Washington Hospital	Prince George's County: 16.1% Charles County: 8.9% http://www.census.gov/	Prince George's County: 15.07% Charles County: 10.98% Maryland Medicaid eHealth Statistics, MD DHMH (http://www.md-medicaid.org/mco/mco-enrollment_action.cf)

2. For purposes of reporting on your community benefit activities, please provide the following information:
   a. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary). Some statistics may be accessed from:
      - The Maryland State Health Improvement Process. http://dhmh.maryland.gov/ship/
      - The County Health Profiles 2013 http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx
      - The Maryland Vital Statistics Administration. http://vsa.maryland.gov/html/reports.cfm
      - The Maryland Plan to Eliminate Minority Health Disparities (2010-2014). http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf
      - Maryland ChartBook of Minority Health and Minority Health Disparities 2nd Edition http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and average age)	Population Prince George's County- 863,420 Charles County- 146,551 Sex Prince George's County Men- 48% Women- 52% Charles County Men- 48.3% Women- 51.7% Race/Ethnicity Prince George's County African American- 64.5% White- 19.2% Asian- 4.1% Hispanic- 14.9% Two or more races- 3.2% Charles County African American- 41.0% White- 50.3% Asian- 3.0% Hispanic- 4.3% Two or more races- 3.7% Median Age Prince George's County- 34.9 Charles County- 37.4
Median Household Income within the CBSA	Prince George's County- $73,447 Charles County- $92,135
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Prince George's County- 8.2% Charles County- 5.6%
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Prince George's County- 15% Charles County- 7.1%
Percentage of Medicaid recipients by County within the CBSA.	Prince George's County- 5.9% Charles County- 6.3%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).See SHIP website: http://dhmh.maryland.gov/ship/SitePages/objective1.aspxand county profiles:http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Prince George's County- 77.8 Charles County- 78.1
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Prince George's County- African American-987 White-782

	Charles County- African American-879 White-809 (per 100,000)
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health statusby County within the CBSA. (to the extent information is available from localor county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information:http://dhmh.maryland.gov/ship/SitePages/measures.aspx	Prince George's County- 85.8% high school graduate or higher; 64.4% drive alone to work; 17.6% use public transportation to commute to work; 17.5% of adults are unable to afford to see a doctor Charles County- 90.6% high school graduate or higher; 77.5% drive alone to work; 6.7% use public transportation to commute to work; 8.9% of adults are unable to afford to see a doctor
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.	Prince George's County-19.8% speak a language other than English Charles County- 6.9% speak a language other than English
Other	Unemployment rate within the CBSA http://factfinder2.census.gov Prince George's County- 8.8% Charles County- 6.8%

b. Please use the space provided to complete the description of your CBSA. Provide any detail that is not already stated in Table II (you may copy and paste the information directly from your CHNA).

Prince George's County

Prince George's County was established in the 17th century and encompasses a mix of urban, suburban, and rural communities. The county is predominately African American with an increasing Hispanic, immigrant, and non-English speaking population. Minorities account for 79 percent of the county's population.

A large range of health issues significantly affect the residents of Prince George's County. The leading cause of death is cardiovascular disease, currently affecting 28 percent of residents. The county's age-adjusted death rate from cardiovascular disease is 280.4 per 100,000 population–significantly higher than Maryland's rate of 252.8 per 100,000 population (DHMH Vital Statistics Administration and Family Health Administration). According to the 2012 County Health Rankings, 16 percent

of adults in Prince George's County, ages 19 and older, smoke, which can also have a negative effect on cardiac health outcomes.

Obesity is also a significant issue among residents. According to the 2010 Behavioral Risk Factor Surveillance System data, 70 percent of residents are overweight or obese; the highest in the state and nation. Diabetes, tobacco use and other cardiovascular disease-related risk factors are also prevalent among the population. The age-adjusted death rate for diabetes in the county (African American: 47.1 per 100,000 population African American; white: 21.9 per 100,000 population) is notably higher than Maryland (African American: 34.3 per 100,000 population; white: 21.7 per 100,000 population).

Despite the high demand for healthcare in the community, Prince George's County is experiencing a shortage of primary care physicians and specialists. The majority are concentrated in more affluent areas of the county, limiting access in lower income communities. Access to emergency care is adequate–Prince George's County houses several hospitals serving its residents. Healthcare for uninsured and underinsured residents is limited–few resources are available to serve these populations.

Data taken from the Prince George's County Health Improvement Plan 2011 to 2014 and the Assessing Health and Health Care in Prince George's County Rand Report.

Charles County

Although Charles County is currently a predominantly white community, African American and Hispanic populations have significantly increased in the past decade. The county's once rural geography is rapidly evolving into a more suburban area, with an increased presence of commercial and residential dwellings.

Health issues in Charles County are consistent with those identified in Prince George's. Obesity, diabetes, tobacco use, and other risk factors related to cardiovascular disease are common among Charles County residents. Of the adult population, 70.6 percent are overweight, compared to 29.4 percent of persons of a healthy weight (MD BRFSS, 2010). The age-adjusted death rate for diabetes in the county is 34.1 per 100,000 population (MD Vital Statistics Report, 2009). The high prevalence of obesity is a contributing factor to Charles County's high diabetes death rate. Heart disease is the

leading cause of death in Charles County. The age-adjusted death rate from heart disease is 228.5 per 100,000 (MD Vital Statistics Report, 2009). Obesity and diabetes are two leading contributing factors to heart disease incidence.

Data taken from the Charles County Health Improvement Plan.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscalyear 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, the IRS defines a CHNA as a:

> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA) must include the following:

A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons

(whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

Examples of sources of data available to develop a CHNAinclude, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP) (http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) The Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) Local Health Departments (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);

(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(12) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNAinvolving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(13) Survey of community residents; and
(14) Use of data or statistics compiled by county, state, or federal governments.

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the Public and adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need; or
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

X Yes
_ No

Provide date here.6/30/2013

If no, please provide an explanation

If you answered yes to this question, provide a link to the document here.

http://www.medstarhealth.org/Documents/MedStar-Health-Center/MSMHC-Full-Report-CHA-2013.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

X Yes
_ No

If no, please provide an explanation

If you answered yes to this question, provide a link to the document here.

http://www.medstarhealth.org/Documents/MedStar-Health-Center/MSMHC-Full-Report-CHA-2013.pdf Pages 25-34

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?
    a. Is Community Benefits planning part of your hospital's strategic plan?

X Yes
_ No

If no, please provide an explanation

    b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB processand provide additional information if necessary):

i. Senior Leadership

1.X CEO
2.X CFO
3.X Other (Please Specify)
Vice President of Marketing and Community Relations

ii. Clinical Leadership

1.X Physician

2.X Nurse

3._ Social Worker

4._ Other (Please Specify)

iii.Community Benefit Department/Team

1.X Individual (please specify FTE)

Community Benefit Liaison – 1 FTE

2._ Committee (please list members)

3.X Other (Please Specify)

Community Outreach Manager – 1 FTE;
Community Outreach Coordinator- 1 FTE;
Community Outreach Assistant- .5 FTE,
Community Health Assessment - Advisory Task Force

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet X Yes _ No

If you answered no to this question, please explain why?

Narrative X Yes _ No

If you answered no to this question, please explain why?

d. Does the hospital's Board review and approve the FY Community Benefit report
that is submitted to the HSCRC?

Spreadsheet X Yes _ No

If you answered no to this question, please explain why?

Narrative X Yes _ No

If you answered no to this question, please explain why?

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each

initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Please be sure these initiatives occurred in the FY in which you are reporting.

For example for each principal initiative, provide the following:

a Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.

b. Name of Initiative: insert name of initiative.

c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)

d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

e. Key Partners in Development/Implementation: Name the partners(community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

f. How were the outcomes of the initiative evaluated?

g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?

h. Continuation of Initiative: Will the initiative be continued based on the outcome?

i Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

Initiative 1

Identified Need	High incidence of stroke in CBSA. High prevalence of stroke risk factors in CBSA.
Hospital Initiative	Stroke Support Group
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To provide education and resources that target stroke survivors, their families, and caretakers.
Single or Multi-Year InitiativeTime Period	Multi-year initiative; Began in 2009
Key Partners and/or Hospitals in initiative development and/or implementation	N/A
How were the outcomes evaluated?	Number of encounters
Outcome (Include process and impact measures)	121 total encounters (December 2012 – June 2013) Approximately 20 stroke survivors, caregivers and family members attended this monthly program on average.
Continuation of Initiative	Yes, with some modifications. Potential partnering organizations will be identified. Guest speakers and presenters will be incorporated more frequently.
Cost of initiative for current FY?	Cost of program includes staff hours and materials: $1,416.24

Initiative 2

Identified Need	High prevalence of hypertension
Hospital Initiative	Mall Walker Program
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To increase the number of members who are aware of their blood pressure status.
Single or Multi-Year InitiativeTime Period	Multi-year initiative; Began in 1989
Key Partners and/or Hospitals in initiative development and/or implementation	St. Charles Towne Center Mall
How were the outcomes evaluated?	Number of encounters
Outcome (Include process and impact measures)	8,161 total encounters (December 10, 2012 – June 30, 2013) 8,161 blood pressure screenings were administered. Physicians and other medical professionals gave monthly presentations to participants on related topics.
Continuation of Initiative	Yes, with some modifications. Potential additional sites will be identified and considered for expansion. Will also implement a new data collection methodology to track blood pressures over time.
Cost of initiative for current FY?	Cost of program includes staff hours and materials: $2,180.98

Initiative 3

Identified Need	High prevalence of hypertension
Hospital Initiative	Free Solarium Blood Pressure Screenings
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To increase the number of CBSA members who are aware of their blood pressure status.
Single or Multi-Year InitiativeTime Period	Multi-year initiative; Began in 1998
Key Partners and/or Hospitals in initiative development and/or implementation	N/A
How were the outcomes evaluated?	Number of encounters
Outcome (Include process and impact measures)	254 total encounters (December 2012 – June 2013) 254 blood pressure screenings were administered.
Continuation of Initiative	Yes, with some modifications. Increase advertising/promotion of program to encourage increased participation.
Cost of initiative for current FY?	Cost of program includes staff hours and materials: $2,484

Initiative 4

Identified Need	
Hospital Initiative	
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	
Single or Multi-Year InitiativeTime Period	
Key Partners and/or Hospitals in initiative development and/or implementation	
How were the outcomes evaluated?	
Outcome (Include process and impact measures)	
Continuation of Initiative	
Cost of initiative for current FY?	

Initiative 5

Identified Need	
Hospital Initiative	
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	
Single or Multi-Year InitiativeTime Period	
Key Partners and/or Hospitals in initiative development and/or implementation	
How were the outcomes evaluated?	
Outcome (Include process and impact measures)	
Continuation of Initiative	
Cost of initiative for current FY?	

2. Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

Yes. Substance abuse and HIV/AIDS have been identified as health priorities by both the Prince George's County and Charles County Community Health Improvement Plans. These issues have not been addressed within MedStar Southern Maryland's community benefits program for two reasons: 1) MedStar Southern Maryland does not have the expertise or specialized knowledge to adequately address these health issues; 2) Prince George's County Health Department is leading such initiatives. The hospital will partner with the health department as appropriate.

V. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Physician leadership and case management staff has identified the following areas of concern:

- Limited availability of inpatient and outpatient psychiatry services
- Limited availability of inpatient and outpatient substance abuse programs
- Limited availability of colorectal surgeons

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the categoryof subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Skilled Nursing Care

This department fills the gap in the care between acute care and home (or nursing home). This service allows the hospital to discharge patients who do not require the services of acute care (as defined by payors, i.e. Medicaid) and yet have not fully recovered from their illness/injury to be sent home. Members of the community benefit from having this service available. However, third party reimbursement for this service is very limited and usually does not cover direct costs. The difference between the reimbursement and the direct cost is considered a community benefit.

Appendix I - Describe FAP

Appendix I – Description of Financial Assistance Policy (FAP)

MedStar Southern Maryland prepares its FAP, or a summary thereof, in:

- English and Spanish.
- a culturally sensitive manner.
- at a reading comprehension level appropriate to the patient population
- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to be present.
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process.
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients with discharge materials.
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills.
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

Appendix II - Hospital FAP

MedStar Health

Corporate Policies

Title:	**Hospital Financial Assistance Policy**	**Section:**	
Purpose:	To ensure uniform management of the MedStar Helath Corporate Financial Assistance Program within all MedStar Health Hospitals.	**Number:**	
Forms:		**Effective Date:**	07/01/2011

Policy

1. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured patients within the communities we serve who lack financial resources have access to necessary hospital services. MedStar Health and its healthcare facilities will:

   1.1 Treat all patients equitably, with dignity, with respect and with compassion.
   1.2 Serve the emergency health care needs of everyone who presents at our facilities regardless of a patient's ability to pay for care.
   1.3 Assist those patients who are admitted through our admissions process for non-urgent, medically necessary care who cannot pay for the care they receive.
   1.4 Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep its hospitals' doors open for all who may need care in the community.

Scope

1. In meeting its commitments, MedStar Health's facilities will work with their uninsured patients to gain an understanding of each patient's financial resources prior to admission (for scheduled services) or prior to billing (for emergency services). Based on this information and patient eligibility, MedStar Health's facilities will assist uninsured patients who reside within the communities we serve in one or more of the following ways:

   1.1 Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
   1.2 Assist with consideration of funding that may be available from other charitable organizations.
   1.3 Provide charity care and financial assistance according to applicable guidelines.
   1.4 Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
   1.5 Offer periodic payment plans to assist patients with financing their healthcare services.

Definitions

1. **Free Care**

   Financial assistance for medically necessary care provided to uninsured patients in households between 0% and 200% of the FPL.

2. **Reduced Cost-Care**

   Financial assistance for medically necessary care provided to uninsured patients in households between 200% and 400% of the FPL.

3. **Medical Hardship**

Medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

4. **Maryland State Uniform Financial Assistance Application**

   A uniform data collection document developed through the joint efforts of Maryland hospitals and the Maryland Hospital Association.

5. **Maryland Patient Information Sheet / MedStar Patient Information Sheet (Non-Maryland Hospitals)**

   A patient education document that provides information about MedStar's Financial Assistance policy, and patient's rights and obligations related to seeking and qualifying for free or reduced cost medically necessary care.

Responsibilities

1. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients. Additionally, the Maryland Patient Information Sheet / MedStar's Patient Information Sheet will be provided to inpatients on admission and at time of final account billing.

2. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. The charity care, financial assistance, and periodic payment plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:

   2.1 Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.

   2.2 Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.

   2. 3Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

   2. 4 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.

   2 .5 Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

   2.6 It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

3. Uninsured patients of MedStar Health's facilities may be eligible for charity care or sliding-scale financial assistance under this policy. The financial counselors and financial services staff will determine eligibility for charity care and sliding-scale financial assistance based on review of income for the patient and their family (household), other financial resources available to the patient's family, family size, and the extent of the medical costs to be incurred by the patient.

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

4.1 Federal Poverty Guidelines. Based on family income and family size, the percentage of the then-current Federal Poverty Level (FPL) for the patient will be calculated.

4.1.1 Free Care: Free Care will be available to uninsured patients in households between 0% and 200% of the FPL.

4.1.2 Reduced Cost-Care: Reduced Cost-Care will be available to uninsured patients in households between 200% and 400% of the FPL. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

4.1.3 Ineligibility. If this percentage exceeds 400% of the FPL, the patient will not be eligible for Free Care or Reduced-Cost Care assistance (unless determined eligible based on Medical Hardship criteria, as defined below).

4.2 Basis for Calculating Amounts Charged to Patients: Free Care or Reduced-Cost Care Sliding Scale Levels:

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

4.3 **MedStar Health Hospitals** will comply with IRS 501(r) requirements on limiting the amounts charged to uninsured patients seeking emergency and medically necessary care.

4.3.1 Amounts billed patients who qualify for financial assistance will be an average of the three best negotiated commercial rates.

4.3.2 MedStar Health will calculate the average of the three best negotiated commercial rates annually.

4.3.3 Maryland hospitals are prohibited from contacting with commercial payor. Charges are regulated by the Health Services Cost Review Commission (HSCRC) and will define the limits of the amount charged to all patients including the uninsured.

5. **FINANCIAL ASSISTANCE: ADDITIONAL FACTORS USED TO DETERMINE ELIGIBILITY FOR MEDICAL ASSISTANCE: MEDICAL HARDSHIP.**

5.1 MedStar Health will evaluate patients for Medical Hardship Financial Assistance if they exceed the 400% of the FPL and are deemed ineligible for Free Care or Reduced-Cost Care.

5.2 Medical Hardship is defined as medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

5.3 MedStar Health will provide Reduced-Cost Care to patients with income below 500% of the FPL that, over a 12 month period, has incurred medical debt at the same hospital in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

5.4 A patient receiving reduced-cost care for medical hardship and the patient's immediate family members shall receive/remain eligible for Reduced-Cost medically necessary care when seeking subsequent care for 12 months beginning on the date which the reduced-care was received. It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

5.5 If a patient is eligible for both Free Care / Reduced-Cost Care, and Medical Hardship, the hospital will employ the more generous policy to the patient.

5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

	Financial Assistance Level – Medical Hardship	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
Less than 500%	**Not to Exceed 25% of Household Income**	**Not to Exceed 25% of Household Income**

6. **METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE: INCOME AND ASSET DETERMINATION.**

6.1 Patients may obtain an application for Financial Assistance Application:
- 6.1.1 On Hospital websites
- 6.1.2 From Hospital Patient Financial Counselor Advocates
- 6.1.3 By calling Patient Financial Services Customer Service

6.2 MedStar Health will evaluate the patient's financial resources **EXCLUDING**:

- 6.2.1 The first $250,000 in equity in the patient's principle residence
- 6.2.2 Funds invested in qualified pension and retirement plans where the IRS has granted preferential treatment
- 6.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc

6.3 MedStar Health will use the Maryland State Uniform Financial Assistance Application as the standard application for all MedStar Health Hospitals. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.

6.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar will consider for eligibility all accounts (including bad debts) 6 months prior to the application date.

7. PRESUMPTIVE ELIGIBILTY

7.1 Patients already enrolled in certain means-tested programs are deemed eligible for free care on a presumptive basis. Programs eligible under the MedStar Health financial assistance program include, but may not be limited to:

- 7.1.1 Maryland Primary Adult Care Program (PAC)
- 7.1.2 Maryland Supplemental Nutritional Assistance Program (SNAP)
- 7.1.3 Maryland Temporary Cash Assistance (TCA)
- 7.1.4 Maryland State and Pharmacy Only Eligibility Recipients
- 7.1.5 DC Healthcare Alliance or other Non-Par Programs

7.2 Additional presumptively eligible categories will include with minimal documentation:

- 7.2.1 Homeless patients
- 7.2.2 Deceased patients with no known estate
- 7.2.3 Members of a recognized religious organization who have taken a vow of poverty
- 7.2.4 All patients based on other means test scoring campaigns
- 7.2.5 All secondary balances after primary Medicare insurance where patients meet income and asset eligibility tests
- 7.2.6 All spend-down amounts for eligible Medicaid patients.

8 MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

8.1 In the event a patient is denied financial assistance, the patient will be provided the opportunity to appeal the MedStar Health denial determination.

8.2 Patients are required to submit a written appeal letter to the Director of Patient Financial Services with additional supportive documentation.

8.3 Appeal letters must be received within 30 days of the financial assistance denial determination.

8.4 Financial assistance appeals will be reviewed by a MedStar Health Appeals Team. Team members will include the Director of Patient Financial Services, Assistance Vice President of Patient Financial Services, and the hospital's Chief Financial Officer.

8.5 Denial reconsideration decisions will be communicated, in writing, within 30 business days from receipt of the appeal letter.

8.6 If the MedStar Health Appeals Panel upholds the original denial determination, the patient will be offered a payment plan to the patient.

9. PAYMENT PLANS

9.1 MedStar Health will make available payment plans to uninsured patients with income between 200% and 500% of the FPL.

9.2 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet

these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

10 **BAD DEBT RECONSIDERATIONS AND REFUNDS**

10.1 In the event a patient who, within a two (2) year period after the date of service was found to be eligible for free care on that date of service, MedStar will initiate a review of the account(s) to determine the appropriateness for a patient refund for amounts collected exceeding $25.

10.2 It is the patient's responsibility to request an account review and provide the necessary supportive documentation to determine free care financial assistance eligibility.

10.3 If the patient failed to comply with requests for documentation, MedStar Health will document the patient's non-compliance. The patient will forfeit any claims to a patient refund or free care assistance.

10.4 If MedStar Health obtains a judgement or reported adverse information to a credit reporting agency for a patient that was later to be found eligible for free care, MedStar Health will seek to vacate the judgement or strike the adverse information.

Exceptions

1 **PROGRAM EXCLUSION**

MedStar Health's financial assistance program excludes the following:

1.1 Insured patients who may be "underinsured" (e.g. patient with high deductibles/coinsurance)

1.2 Patient seeking non-medically necessary services, including cosmetic procedures

1.3 Non-US Citizens,

1.3.1 Excluding individuals with permanent resident /resident alien status as defined by the Bureau of Citizenship and Immigration Services has issued a green card. MedStar will consider non-US citizens who can provide proof of residency within the defined service area.

1.4 Patients residing outside a hospital's defined zip code service area

1.4.1 Excluding patient referral between MedStar Health Network System

1.4.2 Excluding patients arriving for emergency treatment via land or air ambulance transport

1.4.3 Specialty services specific to each MedStar Health hospital and approved as a program exclusion

1.4.3.a Union Memorial Hospital – Cardiac Service, Hand Center, and Renal Patients
1.4.3.b Georgetown University Hospital – Transplant, and Cyber Knife Patients
1.4.3.c Washington Hospital Center – Cardiac Service Patients
1.4.3.d Good Samaritan Hospital – Renal Patients
1.4.3.e Franklin Square Hospital – Cyber Knife Patients

1.5 Patients that are non-compliant with enrollment processes for publicly –funded healthcare programs, charity care programs, and other forms of financial assistance

As stated above, patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to

meet these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

What Constitutes Non-Compliance

Actions or conduct by MedStar Health employee or contract employee in violate of this Policy.

Consequences of Non-Compliance

Violations of this Policy by any MedStar Health employee or contract employee may require the employee to undergo additional training and may subject the employee to disciplinary action, including, but not limited to, suspension, probation or termination of employment, as applicable.

Explanation And Details/Examples

N/A

Requirements And Guidelines For Implementing The Policy

N/A

Related Policies

N/A

Procedures Related To Policy

Admission and Registration
Financial Self Pay Screening
Billing and Collections
Bad Debt

Legal Reporting Requirements

HSCRC Reporting as required – Maryland Hospitals Only
Year End Financial Audit Reporting
IRS Reporting

Reference To Laws Or Regulations Of Outside Bodies

Maryland Senate Bill 328 Chapter 60 – Maryland Hospitals Only
COMAR 10.37.10 Rate Application and Approval Procedures – Maryland Hospitals Only
IRS Regulations Section 501(r)

Right To Change Or Terminate Policy

Any change to this Policy requires review and approval by the Legal Services Department.
Proposed changes to this Policy will be discussed with all affected parties at both the Business Unit and Corporate levels of the Organization.
The Corporation's policies are the purview of the Chief Executive Officer (CEO) and the CEO's management team

Reference:	
Approved By:	 Michael J. Curran, Executive Vice President and CFO
Additional Signature Information:	

Appendix III - Patient Information Sheet

Appendix III – Patient Information Sheet

Hospital Financial Assistance Policy

MedStar Southern Maryland Hospital Center is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability, you may qualify for **Free or Reduced Cost Medically Necessary Care.**

MedStar Southern Maryland Hospital Center meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 400% of the federal poverty level.

Patients' Rights

MedStar Southern Maryland Hospital Center will work with their uninsured patients to gain an understanding of each patient's financial resources.

They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
If you believe you have been wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below)

Patients' Obligations

MedStar Southern Maryland Hospital Center believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

Cooperate at all times by providing complete and accurate insurance and financial information.
Provide requested data to complete Medicaid applications in a timely manner.
Maintain compliance with established payment plan terms.
Notify us timely at the number listed below of any changes in circumstances.

Contacts:

Call (301) 877-4262 with questions concerning:

Your hospital bill
Your rights and obligations with regards to your hospital bill

How to apply for Medicaid
How to apply for free or reduced care

For more information about Maryland Medical Assistance
Contact your local Department of Social Services
1-800-332-6347
TTY 1-800-925-4434
Or visit: www.dhr.state.md.us

Physician charges are not included in hospital bills and are billed separately.

Also available in Spanish

Appendix VI - Mission, Vision, Value Statement

Appendix VI – Mission, Vision and Values

Mission and Values

MedStar Southern Maryland is a full-service, regional healthcare facility founded in 1977 to provide a complete range of inpatient, outpatient and community services for the residents of Southern Maryland. At MSMHC, highly skilled health professionals efficiently deliver respectful and compassionate care using the most advanced medical technology.

MedStar Southern Maryland is a resource center seeking to prevent illness and promote health through education and screening. Our goal is to assist the residents of Southern Maryland in achieving the highest possible level of physical and mental health, and thereby improve the quality of life in our community.

MedStar Southern Maryland continuously evaluates all the clinical services we provide and continuously seeks to improve the delivery of care to patients. Each MedStar Southern Maryland associate, medical staff member and volunteer is motivated by an uncompromising commitment to quality.

The associates, medical staff, and volunteers of MedStar Southern Maryland hold in common the following values with respect to our patients and our professional relationships.

Quality: We perform each task to the best of our abilities and never cease to try to do better.

Respect: We acknowledge the dignity of every individual and appreciate each other's differences and uniqueness.

Integrity: We are forthright with our patients and each other. We fulfill our tasks promptly, accurately, and completely.

Safety: We are committed to improving patient safety and reducing risks for patients and others, including healthcare providers.

Flexibility: We continuously adjust our methods to serve our patients, and we readily embrace change and new technology.

Efficiency: We manage our work to conserve resources and hold down the costs of healthcare without compromising patient care.

Confidentiality: We protect the rights of our patients and their families and safeguard their privacy.

Accountability: We accept responsibility for the results of our work and set aside personal interests for the good of our patients.