MedStar Health

10980 Grantchester Way
Columbia, MD 21044
410-772-6500 PHONE
410-715-3754 FAX
MedStarHealth.org

August 23, 2018

Kevin McDonald
Chief, Certificate of Need
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: MedStar Franklin Square Kidney Transplant Service- Matter # 17-03-2405

Dear Mr. McDonald:

Attached please find our response to your letter dated August 6, 2018, and received on August 10th. Should you have any questions regarding this matter, feel free to contact me at (410) 772-6689.

Sincerely,

Patricia G. Cameron
Director, Regulatory Affairs - Maryland

cc: Paul Parker
Gregory Branch, MD, Health Officer, Baltimore County

1. MFSMC's approach to making probable determination of charity care eligibility within two business days may not meet the standard, and should be further explained. The financial assistance application, provided as Attachment A in response to our question, appears to be one that would be more appropriate for a final determination of eligibility. This subsection of the standard provides that: *"[w]ithin two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility."*

   This requirement means that the hospital should have both a policy and a simple and expeditious process that assure that a person seeking charity care or reduced fees, will be informed of probable eligibility for charity care or reduced fee services within two business days of an initial request. It is permissible for the hospital to have a two-step process. Step One may be based on an abridged set of information, but must result in the hospital's communicating its determination of probable eligibility to the potential patient (or family) within two business days of the request. Step Two, the final determination of eligibility for charity care or reduced fees, can be based on a completed application with required documentation.

   The policy and any procedures should make it clear what information is required – and may well be just an interview that discusses family size, insurance, and income – in order to issue a determination of probable eligibility. A final determination may require further documentation. It would be helpful for MFSMC to submit a copy of the hospital's procedures that outline how its staff makes a determination of probable eligibility (and that tell hospital staff how to do it).

Response

As stated in our application, MedStar Health is committed to ensuring that uninsured and underinsured patients have access to emergency and medically necessary hospital services. MedStar Franklin Square Medical Center's (MFSMC) financial assistance policies include procedures for determining probable eligibility for financial assistance (charity care) as well as the final determination for financial assistance and enrollment in Medical Assistance.

MFSMC makes a determination of probable eligibility for charity care within two business days of the patient's initial request. MedStar's written procedure followed by our patient advocates for determining probable eligibility for financial assistance or Medical Assistance describes the screening process for Medicaid eligibility, and for determining eligibility for financial assistance. See Attachment A. Attachment B is the Probable Financial Assistance Eligibility Data Questionnaire used in this process.

The screening process for either Medical Assistance or financial assistance eligibility that is followed by our patient advocates is further outlined in the Probable Financial Assistance Determination and Financial Assistance Checklist. See Attachment C. This assures that patients will be informed of their probable eligibility for charity care within two business days of a request.

2. Please specify the source of the data presented in Tables 1, 2, and 3.

Response

The source for all three tables is OPTN data. The specific source for Table 1, on page 12 of our June 1, 2018 submission, is:

> ABDOMINAL VOLUME: https://optn.transplant.hrsa.gov/data/view-data-reports/buildadvanced/ . Data filtered by 1.Transplant 2.Transplant Year=2016, 3. Transplant Center, Organ- exclude thoracic organs, and sorted largest to smallest for sum of all abdominal organs

For Tables 2 and 3, on pages 13 and 15, is:

> KIDNEY VOLUME (aggregate kidney and SPK volume): https://optn.transplant.hrsa.gov/data/view-data-reports/build-advanced/. Data filtered by 1. Transplant, Organ = Kidney, Year = 2016, 2.Any, 3.Transplant Center. Aggregate with filters by 1. Transplant, Organ = Kidney /Pancreas, Year 2.Any, 3.Transplant Center.

3. Please elaborate on your statement at the end of the response to question 13 that: "The improvement in patient care that results from receiving all available options in transplant care within one integrated system is a substantial benefit that the proposed program brings Maryland patients," perhaps by contrasting that scenario with one FSMC considers less optimal.

Response

MedStar Health believes that patients benefit from care within one system from a variety of perspectives, importantly, the following:

- Continuity among providers who work together consistently and whose experience and expertise is familiar to each benefits the coordination of care between subspecialties;
- Ready, ongoing communication of specific patient details between providers through a common medical record facilitates prompt, effective and efficient care;
- Transitions between levels of care - at familiar sites of service (i.e., inpatient to rehabilitation to outpatient and vice versa) are smoother for providers and patients;
- "Significant others" develop familiarity with the rhythms of care within one system, making navigation more manageable and comfortable.
- Cost-savings accrue through greater efficiency in patient management and less redundancy in testing, travel and billing processes.

Less optimal are scenarios where patients must navigate between disparate providers who are personally unfamiliar with one another, whose systems of documentation vary and do not communicate important details of the medical record with one another, and that involve multiple ancillary providers that may or may not be affiliated directly with the system. All of these circumstances are "set ups" for duplication in services and confusion and distrust among providers and patients -- ultimately driving up costs for the patient and the health care system overall.

4. Your response to question 15, which asked for "a summary description of the impact of the proposed project on costs and charges of the applicant hospital," provided the impact on costs, but did not address its impact on charges. Please do so.

Response

In its original application, MFSMC provided financial and workforce tables that combined together the impact of the proposed liver and kidney transplant programs. In response to Staff's request in its first set of Completeness Questions, MFSMC resubmitted its financial and workforce tables, providing one set of tables for it proposed kidney transplant program and one set for its proposed liver transplant program. Per Table *K - New Facility,Serv – Inflated* - of its resubmitted tables, MFSMC estimates its proposed kidney transplant program will have the following impact on hospital charges:

Program Year	Net Impact on Charges
Year 1	$1.16M
Year 2	$3.11M
Year 3	$5.74M

Attachment A

MedStar Health

MedStar Health

Professional Support Services

Patient Financial Services
Unscheduled Self pay

Submitted By:

Helen Peltsemes Date: _____
Supervisor, Patient Advocacy

John Bruchalski Date: _____
Manager, Patient Advocacy and Collections

Renee Massey Date: _____
Director, Collections

Administrative Approval:

Catherine Foster, AVP, Patient Financial Services Date: _____

Susan Whitecotton, VP, Patient Financial Services **Date:** _____

Effective Date: 6/28/2001
Revision Date: 5/10/16

Expiration Date: _____

Policy Statement:
All Inpatient self-pays and OP selfpays for the defined targeted areas are to be screened for insurance, ability to pay, Medicaid or Financial Assistance. The Advocacy department must meet standard of screening benchmark (minimum of 91%) of the unscheduled self pays.
HPE

REPORTS:
$$A2P565 – unverified self pays/ ma pending
$$A20124 – Observation patients
ALPHA- IN – in-house patients

RESOURCES:
Maryland Health Connection Call Center 855-642-8572

PROCEDURE:

1. Accounts are referred to the Patient Advocates via the McKesson Queue:
    a. ADT report is loaded daily into the McKesson work Queue.
    b. Accounts that are registered with insurance and later found that the patient is not covered are referred to the Patient Advocate from the Central Financial Clearance department via the McKesson work queue
    c. Accounts with Medicare and deductible with no secondary insurance is referred to the Patient Advocate from the Central Financial Clearance department via the McKesson work queue.
2. Check the system for any previous encounters. (Check all hospitals).
3. Perform all of the standard automated insurance verifications. (If the patient is over 65 years old, verify that HDX was initiated).
4. If the patient is employed, contact the employer to inquire if patient is insured.
5. If there was no insurance found via standard automated insurance verification or from the employer, the patient advocate will visit the patient bedside to screen for insurance, ability to pay, Medicaid eligibility or charity care.
6. The patient advocate will update SMS with notes specific to reasons for non-eligibility, information obtained, and information outstanding and assign appropriate service codes indicating the current status of the account.

Screening:

The patient advocate will call the patient's room, introduce himself or herself by stating name and department (patient advocacy) and verify the patient is in room and able to meet. The patient advocate will ask if the patient is covered by primary and/or secondary insurance. If the patient has insurance, follow the following steps:

1. Auto-verify HDX, Blue Line and EVS. Complete the insurance update form on line and email to verifiers. A photocopy of the patient's card should be referred to CBO scanning department to scan in the patient's folder.
2. The patient advocate will follow up on the account in 24 hours to ensure that the verification team has updated the insurance on SMS. If the insurance has not been updated within 24 hours, refer the insurance update to the team leader for further follow up.
3. If the insurance update has been completed and verification performed, check the comments to find out the patient liability. If there is a deductible, copay or coinsurance, the patient advocate will visit the patient at bedside to obtain either secondary insurance information or a payment plan.
4. If the patient does not have insurance, ask the patient to pay all or part of their bill using their credit card. If there is no credit card available, proceed to determine the patient's ability to pay, Medicaid eligibility and the charity care potential.

The following steps define a proper screening of self-pay patients at bedside:

1. The patient advocate must maintain all patient information within the portfolio when passing through the floors of the hospital. The patient advocate will take all pertinent information when making a visit to the patient's room (i.e. POA, MA application, charity application etc.)
2. When making the visit to the patient's room, the patient advocate will introduce himself or herself by stating their name and department (patient advocacy).
3. Observe the patient's confidentiality by knocking before entering the patient's room. If semi-private room ask if the privacy curtain can be drawn and pull the curtain.
4. The patient advocate will explain to the patient that he or she was admitted without insurance. The patient advocate will confirm that per our phone conversation the patient has no insurance. The patient advocate will then ask the patient how the hospitalization will be paid. If the patient has the ability to pay, follow the **Payment Arrangement Policy**.
5. The patient advocate will be responsible for collecting payments and providing the patient

with a receipt. The patient advocate will be responsible for taking all payments through US Bank on the lap tops. The patient advocate will make a copy of the receipt and file. (The receipt must list the patient account number, the payment amount and patient name). The patient advocate will document SMS with the assigned receipt number, amount of payment, amount of discount (if any) and date of payment.

6. **All accounts where the patient has set up an agreeable payment plan per the installment procedure should be updated with insurance plan code of 'P88" on SMS.** The patient advocate will document SMS with the payment arrangement in the comments.
7. The patient advocate must notify the patient that failure to pay as agreed may result in the account being referred to a collection agency. If the patient has any question regarding their payment plan once they have been discharged will need to contact the Customer Service Department at (410) 933-2424.
8. If the patient states that he or she cannot afford to pay the bill, the patient advocate will proceed to Medicaid eligibility screening below.

Medicaid and QHP Eligibility:

1. If the patient states they do not have the ability to pay and the patient has a SSN, the Patient Financial Advocate will advise the patient that they can assist with applying the patient for Medicaid through the on line HPE and Maryland Health Connection portal.
2. The Patient Financial Advocate will complete the HPE worksheet and have the patient sign the authorization to assist them to create an account and sign up for Medicaid.
3. If the patient meets the criteria on the HPE Worksheet, the advocate will proceed to enter the information on line in HPE eMedicaid portal.
4. The Patient Financial Advocate will also complete the Medical Assistance application in the Maryland Health Connection Portal and Financial Assistance application with the patient.
5. If the patient qualifies for Medicaid via the portal, the advocate will place the account in T98 plan code and enter the HPE Medicaid determination along with the eligibility dates. The advocacy will also obtain any information requested and upload in the MHC portal.
6. The Patient Financial Advocate will follow the case until converted or the patient is found uncooperative in the Medicaid application process.
7. The Patient Financial Advocate is not allowed to participate in the patient's selection of an MCO. The patient will need to be referred to the call center or Navigator to select an MCO.
8. If the patient qualifies for a Qualified Health Plan (QHP), the patient will be provided information to log into the MHC for the patient review the policy options to enroll with insurance.
9. If the patient income qualifies them for a Medicaid, but the patient is receiving SSDI the patient should apply through the Maryland Health Connection Portal. If the patient is over income the system will refer them to the QHP to enroll for insurance.
10. If the patient qualifies for a QHP and the patient has a disabling diagnosis, refer the account to HSS to complete the disability application process.
11. Undocumented patients cannot apply for Medicaid through the Maryland Health Connection portal unless they met the 5 year Permanent Resident Card criteria. These patients (X02) require a paper Medicaid application. The State Case workers will process the X02 cases and the Patient Financial Advocate will provide all required supporting documents from the 1052 form.

Financial Assistance:

1. If the patient cannot pay the bill and does not qualify for the Medicaid program, the patient

should be advised that he/she is not a candidate for Medicaid (update service code 900084 on SMS). The patient advocate will need to advise the patient he/ she can be considered for charity care write off. SMS must be updated with the specific reasons for Medicaid non-eligibility.

2. The patient advocate is to complete the charity care application with the patient and have the patient sign the completed application. (See charity care application)
3. The patient advocate is to make a copy of the charity care application (front and back) and the wage information and forward to the CBO Scan department via inter- office mail.
4. The patient advocate will advise and provide a list to the patient of all information that will be necessary to complete the Charity application.
5. The patient advocate will advise the patient that if they comply will all information required to process the charity care application that the patient may have all or part of the bill written off. The patient has two weeks from their discharge date to submit all information to the charity care representatives. If all information is not submitted within two weeks, the patient will not be eligible for charity care.
6. If the patient does not qualify for any of the programs, the patient advocate will advise the patient and the reasons that they do not qualify. The patient advocate will advise the patient that they are available for further questions and leave the patient advocate's business card with the patient. Explain that the patient advocate may meet with them again at the time of discharge to review the final disposition. The patient advocate will explain that non-payment could result in collection agency referral.

Psy Admissions

1. The patient advocate will check with in house DSS caseworker to see if the patient is known to the Cares System (DSS system) as having applied for Medicaid prior.
2. If the patient is known to the Cares System, assist patient in gathering the information required completing the Medicaid application, per DSS caseworker instructions.
3. If the Cares System does not list the patient, refer the account to the primary agency using the appropriate service code.

.

The patient advocate outreach staff handles self-pay patients admitted and discharged over a weekend.

Attachment B

MedStar Health

SUBMIT COMPLETED APPLICATION TO:
MEDSTAR HEALTH
Financial Assistance Department
8020 Corporate Drive
Baltimore, MD 21236

PROBABLE FINANCIAL ASSISTANCE ELIGIBILITY DATA QUESTIONNAIRE

MedStar Health will conduct an initial financial screening to determine PROBABLE MedStar Financial Assistance Eligibility. Please provide the following information to assist with the screening process.

1) Total Yearly Family/Household Income: $_____

2) Total Number of Individuals Living in the Household: _____

3) Have you applied for Medical Assistance? _____ Yes _____No

If yes, where and when did you apply._____

4) Do you currently receive benefits from other government programs? _____ Yes ____No

If yes, please identity the program benefits._____

Probable Financial Assistance Eligibility Determination:

Based on a review of the information provided above:

☐ Patient was advised that they are likely eligible for MedStar Financial Assistance for emergency and medically necessary care.

☐ Patient was advised that a financial assistance determination requires additional documentation.

DATE:_____

MEDSTAR FINANCIAL ASSISTANCE DATA REQUIREMENT CHECKLIST

To complete your final eligibility determination, please return a completed MedStar Financial Assistance Application with support documents within fifteen (15) days from the date of this data request. Failure to comply will result in an automatic denial for MedStar Financial Assistance.

DATE REQUEST DATE:_____

****Please return the required documentation attached to this checklist ****

A: MEDSTAR UNIFORM FINANCIAL ASSISTANCE APPLICATION

_____ Complete **in full and sign** attached MedStar Uniform Financial Assistance Application

_____ If you are non-US citizen, please provide copies of permanent resident identification

B: SECTION I. FAMILY INCOME :

_____ 1) Two current pay stubs showing year-to-date income; or 4 months gross income
_____ 2) Most recent income tax return with W2s - Self employed/profit and loss statement
_____ 3) Current Social Security Award Letters, proof of pension and/or DSS Award Letter, Workman's Compensation, TEHMA, SSDI
_____ 4) Unemployment Benefit History Payment Statement or denial
- **Can be obtained at your unemployment office**

_____ 5) Proof of child support
_____ 6) Proof of alimony
_____ **7) Copies of all other forms of income as listed on the MedStar Uniform Financial Assistance Application Section I: FAMILY INCOME**
_____ **8) If claiming zero income, letter of support from person providing financial support.**

C: SECTION II. LIQUID ASSETS

_____ 1) Copies of bank statements for ALL Savings and/or Checking Accounts
_____ 2) Copies of statements for ALL Stocks, Bonds, CD, or Money Market Accounts
_____ 3) If there are no liquid assets, please provide a written/signed letter stating $0 assets.

D : SECTION III. OTHER ASSETS

_____ **1) If you own your home(s) , please provide:**
- **a. Current loan balance: $_____**
- **b. Current home market value: $_____**

E: SECTION IV. MONTHLY EXPENSE

_____ **1) Provide copies of all unpaid medical bills for the past 12 months.**

To discuss your application, please contact our office at 410-933-2424 or 1800-280-9006
Monday – Friday 7:00 am – 7:00 pm.

Attachment C

MedStar Health

Professional Support Services

Patient Financial Services
Probable Financial Assistance Determination and Financial Assistance Checklist

Submitted By:

Renee Massey _____ Date: _____
Director, Patient Financial Services

John Bruchalski _____ Date: _____
Manager, Patient Advocacy and Collections

Helen Peltsemes _____ Date: _____
Supervisor, Patient Advocacy

Administrative Approval:

Susan Whitecotton _____ Date: _____
VP, Patient Financial Services

Debbie Harthman _____ Date: _____
AVP, Patient Financial Services

Effective Date: 09/01/2018
Revision Date: None

Procedure Statement:

In accordance with the MedStar Corporate Financial Assistance Policy, MedStar will provide a determination of probable financial assistance eligibility within two business days following the request or application receipt for full or reduced cost care. MedStar Patient Financial Services Advocates will screen patients for both Medical Assistance and MedStar Financial Assistance, and assist patients with the application processes as needed by the patient.

Inpatient Admissions:

1) MedStar Patient Financial Services Advocates will screen all self pay admissions for Medical Assistance and MedStar Financial Assistance.
2) MedStar Patient Financial Services Advocates will utilize the MedStar Probable Financial Assistance Eligibility Data Questionnaire for the screening process.

3) Based on the results the patient screening, MedStar Patient Financial Services Advocates will provide the patient a Probable Financial Assistance Eligibility determination.
4) MedStar Patient Financial Services Advocates will document additional data requirements needed for a final eligibility determination on the MedStar Financial Assistance Data Requirements Checklist. A copy of the checklist will be provided to the patient.
5) MedStar will make a final financial assistance eligibility determination on receipt of a completed MedStar Corporate Financial Assistance application.
6) Non-cooperative patient are referred to external agencies for outreach after in-house efforts are exhausted.

Pre-Visit / Pre-collection Interview:

1) MedStar Pre-Visit Associates will screen patients requesting financial assistance during the pre-visit interview.
2) The Pre-Visit Associate will provide a probable eligibility determination and advise of additional documents needed to complete the application process.

Financial Assistance Applications Received by Mail:

1) Financial assistance applications are received by the MedStar Financial Assistance Associate for review.
2) MedStar Financial Assistance Associate will review the application. A probable financial eligibility determination letter will be mailed to the patient within 2 business days. The mailing will also include the MedStar Financial Assistance Data Requirements Checklist. The patient must provide the checklist documents within 15 days to support a final eligibility determination.
3) If the patient fails to comply with the data request, MedStar Financial Assistance will be denied.

Procedure Documents:

1) MedStar Corporate Financial Assistance Policy
2) MedStar Probable Financial Assistance Eligibility Data Questionnaire
3) MedStar Probable Financial Assistance Notification Letter
4) MedStar Financial Assistance Data Requirement Checklist