

# MedStar Select/Medicare Choice Provider Newsletter

## MedStar Medicare Choice Pharmacy Benefits

The pharmacy benefits manager for MedStar Medicare Choice is MedStar Medicare Choice Pharmacy Services. A directory of participating pharmacies, the formulary and prior authorization forms are available at **MedStarProviderNetwork.org**. Please utilize these resources to determine if the prescribed drug is on the current formulary and it has any utilization management requirements (i.e. prior authorization, step therapy and/or quantity limits). If your patient must take a non-formulary medication, an exception may be submitted for review.

To request an exception, complete the Non-Formulary Exception form, posted on **MedStarProviderNetwork.org** under Pharmacy Prior Authorization forms. Please remember, if the exception is approved, the non-formulary medication will be covered at the non-preferred brand tier and the patient may still incur significant costs. Please call MedStar Medicare Choice Pharmacy Services at **855-266-0712** with questions.



### Where can MedStar Medicare Choice Members get Their Vaccines?

Medicare beneficiaries MUST receive most of their vaccinations from a pharmacist at a pharmacy (mandated by the Medicare Part D benefit). Exceptions: Influenza, pneumonia and tetanus (following an injury) are covered through the member's medical benefit (Part B) and can be administered at and billed by a pharmacy, a physician's office or an Emergency department.

### Helping Your MedStar Medicare Choice Patients Afford Their Diabetic Care

For many of your patients, caring for their diabetes is not only an emotional challenge, but also a financial one. For some, this financial burden has led to medication adherence issues and other complications. If your patient is struggling financially, patient assistant programs may be available. These programs are typically offered for brand-only medications, and are sponsored by the drug manufacturer. The following two websites can help in determining your patient's eligibility for assistance programs: **NeedyMeds.org** and **Medicare.gov/Pharmaceutical Assistance-Program**. Low-income Medicare patients may also contact the Social Security Administration to determine if they qualify for Medicare Extra Help (low income subsidy), which may reduce their prescription costs. More information can be found at **SocialSecurity.gov/ExtraHelp** or by calling **800-772-1213**. When prescribing for diabetic testing supplies, the covered manufacturers are Lifescan (OneTouch products) and Bayer (Contour products). Please complete the non-formulary request form found on **MedStarProviderNetwork.org** to request a review for coverage of a non-preferred diabetic supplies.

## MedStar Select Annual Enrollment

The annual enrollment period for MedStar Select will begin on Nov. 2, and run through Nov. 18, for benefits beginning on Jan. 1, 2018. The MedStar Select Plan offers comprehensive medical coverage for MedStar Health associates and their dependents through the MedStar Select Provider Network. This network consists of not only MedStar-employed providers, but also a full complement of contracted community providers. The plan offers in-network and out-of-network benefits. You do not have to select a primary care physician (PCP) to coordinate your care and referrals are not necessary for specialty care.

For more information, or to confirm if you are in the MedStar Select Provider Network, visit [MedStarMyHealth.org](http://MedStarMyHealth.org) or call **855-242-4872**.

## Medicare Advantage Annual Enrollment Period

The annual enrollment period for Medicare Advantage plans will begin on Oct. 15, and run through Dec. 7, for benefits beginning on Jan. 1, 2018. MedStar Medicare Choice is offered through MedStar Family Choice, a local, provider sponsored organization and proud member of MedStar Health. MedStar Medicare Choice offers affordable HMO plans that include medical and prescription drug coverage, a \$17 monthly premium, low physician visit copays, no required referrals, and routine vision and dental benefits, in addition to other benefits.

For more information and to enroll, please visit [MedStarMedicareChoice.com](http://MedStarMedicareChoice.com).



## SNP Model of Care

The MedStar Medicare Choice Dual Special Needs (D-SNP) and Chronic Special Needs (C-SNP) plans serve patients eligible for Medicare and Medicaid and patients diagnosed with diabetes and/or congestive heart failure (CHF), respectively.

### What Does this Mean?

These Special Needs Plans (SNP) were approved by CMS under the documentation of an evidence-based Model of Care. The Model of Care is designed to address the unique healthcare needs of the D-SNP and C-SNP population. Importantly, there is also a focus on the socio-economic and behavioral health factors that may impact a patient's ability to manage illness and access quality care. The Model of Care aims to improve the patient's:

- Access to medical, social and mental health services
- Coordination of care across the continuum through a dedicated RN care advisor
- Transitions of care across healthcare settings and providers
- Access to preventative health services
- Health outcomes

### How Does this Impact You, as the Valued Provider?

The Model of Care is a best practice because it offers the following benefits:

- High level of attention to each patient's specific health and individual needs
- Health assessments to identify risks and concerns
- Individualized attention and coordination of care from assigned RN care advisors
- Individualized care plan for all patients enrolled
- Coordination of transitions of care across healthcare settings and providers
- Network providers experienced with SNP members

As a provider caring for SNP patients, CMS requires that you are educated on essential information about Special Needs Plans and special needs patients. For your convenience, we offer various methods to complete this training. A signed attestation of completion is required in order to track completion for CMS reporting. In order to support your members, an online course has been added to **MedStarProviderNetwork.org**.



You will be eligible to receive 1.75 CME credits after answering all questions and completing all information on the Attestation of Course Completion for CME Credits form. Once the attestation form is completed and signed, please fax it to **703-890-1636**.

Upon completion of this course, you will be able to:

- Define SNP and the eligible patient's demographics.
- Describe the Model of Care for our SNP programs and how it improves the patient's health and healthcare experience.
- Understand the key elements of the Model of Care's "whole person" management approach, including the individualized care plan and interdisciplinary care team.
- Identify the measurable performance outcomes.

MedStar Medicare Choice's mission is to serve vulnerable populations with a holistic, integrated model to ensure they receive timely access to quality care in a setting most appropriate for their needs.

### What's Next?

To complete the online SNP Model of Care training, please visit **MedStarProviderNetwork.org**, click on the "Annual Required Training" link to access the training document. In order to obtain 1.75 CMEs, review the training materials, print the attestation form and fax the completed and signed form to **703-890-1636**.

For questions about completing the SNP training and other methods available, please contact your provider relations representative.

# Pharmacy and Star Measures Frequently Asked Questions

This document was developed as a reference guide, providing information about Star pharmacy measures and has been divided into three sections: Helpful Information, Provider Specific Questions and Member Specific Questions.

## HELPFUL INFORMATION

This section shares information about Star Measures and why MedStar Health will be focusing on it this year.

### What are the Center for Medicare and Medicaid Services (CMS) Star Ratings?

CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and participating health systems. Medicare Plans are measured on a five point rating scale. Five is the highest score.

### Why are Star Measures and Rating important?

The five-star program is a key component in financing healthcare benefits for Medicare Advantage beneficiaries. This program encourages quality and performance improvement—with the goal of better medication adherence rates in members.

### Why is MedStar focusing on Star Rating now?

MedStar Medicare Choice wants to ensure the health and wellbeing of our members. By increasing Star measure awareness in our provider community, we hope to encourage quality and performance improvement.

### What do the Five-Star Rating Measures consist of?

CMS bases the five-star rating system on a range of quality metrics, including clinical measures (i.e.: blood pressure control for patients with hypertension), member satisfaction and complaints and medication adherence.

### Which pharmacy measures should MedStar Providers focus on?

Below is a table listing the four quality measures and their specific components.

| Quality Measure                                   | Measure Specifics  |
|---|--|
| Medication Adherence for Diabetes Medications     | Any patient 18 years and older with a diabetes prescription should maintain 80 percent adherence. This includes drug therapy across the following classes of medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics and meglitinides. |
| Medication Adherence for Hypertension Medications | Any patient 18 years and older with a prescription for RAS antagonist medication should maintain 80 percent adherence. This includes ACE, ARB or a direct renin inhibitor drug.  |
| Medication Adherence for Cholesterol Medications  | Any patient 18 years and older with a prescription for cholesterol medication (a statin drug) should maintain 80 percent adherence.  |

## PROVIDER SPECIFIC QUESTIONS

This section offers answers to common questions our provider community may ask as it relates to Star measures and improving pharmacy outcomes.

### I recently received a Pharmacy Adherence Report? What Information is in this report?

Providers who have members eligible for this measure will receive a report called the "Point of Care" report. This report showcases results of patient medication adherence measures and can help identify which members may need some additional assistance with their medications. The adherence measure is calculated based on the number of days a patient has a filled medication out of the 365 days of the year. A patient is considered noncompliant once they fall below 80 percent adherence level. Non-compliant patients lower the overall adherence score for the health plan.

### Some of my patient's adherence rates are lower than I would like. How can I help them?

Your patients may be avoiding their medications for the following reasons:

- Cost
- Unpleasant side effects
- Access
- Forgetfulness

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As their provider, you may be able to help by considering the following:

- Why have they chosen not to continue their medications?
- What generic alternatives are available to them?
- Do they have access to a pharmacy that delivers?
- Are they interested in enrolling in an auto-refill program offered by mail order or a local pharmacy?

### **What will happen if the medication adherence rates of my patients do not improve?**

As a provider-led health plan, our goal is to provide you with the resources necessary to help your patients get and stay healthy. By working closely with your patients and working together with the care advising and pharmacy services team, we are confident most patients' adherence scores will improve. Unfortunately, there may be some patients that are more challenging to work with. Patients whose adherence rates fall below the 80 percent threshold will be considered non-compliant. Because this can reflect poorly on the care delivered by the plan and provider, we are available to work with you in meeting your patient's needs.

### **MEMBER SPECIFIC QUESTIONS**

This section offers answers to some common questions MedStar Medicare Choice members may ask. Please note, members may have questions for the care advising team, member services and/or their provider.

#### **What if I can't afford to pay for my medications?**

There are many low cost generic medications that are available on the plans covered drug list. For help in finding cost effective alternatives, reach out to your provider or call **855-242-4872** to be connected with a care advisor.

#### **What if I can't get to a pharmacy to pick up my prescription?**

If you are having trouble accessing a pharmacy, consider the following solutions:

- Mail Order: Your doctor can call or fax your prescription to an Express Scripts mail order facility and deliver 90 days of medication at a time.
- Delivery Service: Check with your local pharmacy to see if they have a delivery service.

#### **I often forget to take my medication. How can I do a better job of remembering?**

Consider purchasing a pill box that stores your medication by day or time. Your clinical pharmacist can help you do that. In addition, try setting daily reminders on your phone or alarm clock.

#### **I can't recall if there has been a change in my therapy.**

If you do not remember if and how your medication regimen has changed, feel free to reach out to a clinical pharmacist or your provider. When you receive the information you are looking for, we suggest writing it down and creating reminders.

#### **The medication side effects I am experiencing are very uncomfortable. What are my options?**

Taking your prescribed medication is integral to your improved health and management of disease. We do understand, however, that certain side effects can be uncomfortable. Before stopping or changing your medication regimen, please speak with your provider and clinical pharmacist. Together, you may be able to identify alternative medications.

#### **I am not sure that my medication has any effect. Can I stop taking it?**

Your medication is necessary in treating your condition and preventing future catastrophic events. Some medication benefits are not noticeable, and others are prescribed as preventative measures. If you have concerns or questions, please reach out to your provider or clinical pharmacist.

#### **I feel like I don't need my medication anymore and my friends and family agree. Can I stop taking this medication?**

Only your doctor can advise you to stop or change your medication. Remember, some medications are prescribed for prevention only. In addition, abruptly stopping your medication can sometimes cause serious complications. Please reach out to your provider with questions.

#### **What should I talk to my provider about at our next appointment?**

Every visit to your doctor should consist of a comprehensive review of your medications, so your doctor can be informed and better assist you with cost, side effects or other health improvement tactics. If you have questions in between visits, feel free to call your provider's office or clinical pharmacist.

## Effective Communication

Many patients have little experience with medical terminology and keeping it simple makes things easier for the patient to understand. Patients who understand the information their practitioners are presenting to them about their health and treatment are more likely to follow instructions to improve their health.

To communicate effectively with patients, practitioners need to be mindful that each patient is different, so their communication techniques must be diverse as well. Providers should realize that all patients are different, and keeping up to date with various backgrounds, cultures, social and economic issues, past history, etc., could potentially help providers better communicate with their patients on an individual level.

Encouraging patient involvement is also a great tool to bridge the communication gap between providers and patients. Providers must recognize when to call upon the help of the patient's family and friends (with the patient's permission, of course) to assist with communication and cultural differences when needed. Some educational resources include: Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) training, CME, specialty education, and CLAS modules. More resources can be found on the U.S. Department of Health & Human Services Think Cultural Health website at **ThinkCulturalHealth.HHS.gov**. For language barriers, providers should utilize interpretation services, as they are available.

MedStar Medicare Choice members who contact physician offices with benefit questions should be directed to call the Member Services department at **855-222-1041**. Members may also visit our website at **MedStarMedicareChoice.com**.

MedStar Select members can call the Member Services at **855-242-4872** to address any benefit questions. MedStar Select members may also visit **MedStarMyHealth.org** for any additional questions.

Taking all of these steps will help to foster a good relationship between you and your patients.



## Helping Your MedStar Medicare Choice Patients Afford Their Medication

Make sure you know about these Medicare Advantage benefits designed to save your patient's money when getting medication.

### 1. 90-Day Supply (versus 30-Day):

- Filling a 90-day supply of a medication is a good way to save your patients' time and lead to potential cost savings.
- By having a 90-day supply of medicine, your patients' only have to go to the pharmacy four times a year versus 12, saving time and money on transportation.
- This also helps patients to continue to take medicine as you prescribed.

All DSNP and full Low Income Subsidy (LICS) patients are eligible to receive a 90-day supply at the cost of 30 days. All generic drugs on the formulary (or Tier 1) are \$0 to \$3.30 depending on the patient's income level. All brand drugs on the formulary are \$0 to \$8.25 depending on the patient's income level.

To find out if your patient qualifies for the low income subsidy, have your patient contact the Social Security Administration at **SocialSecurity.gov/ExtraHelp** or by calling **800-772-1213**.

### 2. Mail Order Pharmacy Services:

- Mail order pharmacy can be a great convenience as it allows for your patients' medicine to be delivered right to their door. This can save patients' time from traveling to and from the pharmacy, money from transportation and safety from getting out in poor weather conditions.
- Contact Express Scripts mail-order pharmacy at **800-282-2881**. This is also the number listed on the back of patients' insurance card.
  - Remember a 90-day supply is required to enroll in the mail order program.
  - Patients will need to enroll and set up an account.
  - Patients can pay by e-check, check, money order or credit card.

### 3. Auto-refill Program with Local Pharmacy:

- An auto-refill program is a great way to make sure your patients have medicine on time and are able to take it as prescribed each time it is due for a refill.
- It is a free service from the pharmacy, removing the need to call in or drop off refills.
- Most pharmacies call and remind patients when their prescription is ready or contact you when more refills are needed.

### 4. CSNP Patients with Diabetes

- MedStar Medicare Choice offers a Tier 6 pharmacy option for CSNP members with diabetes.
- Tier 6 medications are \$10 per 30-day supply.



## Verification of High Dollar Claims

MedStar Medicare Choice and MedStar Select have a process to review high dollar claims prior to payment to verify accuracy of reimbursement. A high dollar claim is defined as any claim with a total payment amount that is determined to be equal to or greater than \$25,000. Once claims are received via electronic or paper format, those exceeding the dollar threshold amount are held for the Quality Assurance department to complete a comprehensive review prior to payment distribution.

Within two (2) business days of receipt, the representative from the Quality Assurance department reviews the high dollar claim for accuracy. After the claim is reviewed, remarks are added stating if corrections to the claim are required prior to the claim being released. If the claim is correct, it is routed back to the Claims department to be released if the total payment amount is less than \$100,000.

Claims \$100,000 or greater are routed back to the Claims department to be released by a manager. If corrections are needed, it is routed back to the Claims department for corrections prior to release. A small subset of claims also undergo a coding and/or clinical review. The claims forwarded for review include (but are not limited to) when the allowed amount exceeds the billed amount on the claim; or when pharmacy or supply charges seem unusually high.

These reviews could result in a request for medical records to support the services billed, which must be received in order to approve payment. Three outreach attempts will be made. If the information is not received after three attempts, the claim could be denied. Audits are performed on a sample of claims on both a weekly and monthly basis to validate that high dollar claim reviews are being performed accurately and appropriately. For more information on the high dollar claim review process, please contact Provider Services **855-222-1042**.

## Excluded Parties - Payment Ban

According to the Federal guidance, Medicare payment may not be made for items or services furnished or prescribed by a provider or entity who has been excluded from participation in Federal programs. Providers should be aware of this provision and screen all employees and contractors for exclusion upon hire, then monthly thereafter. Payments may be retracted if reimbursement is directly or indirectly related to the excluded parties for items and services provided to a Medicare enrollee.

Prior to hiring an individual and monthly thereafter, providers should review the Department of Health and Human Services Office of the Inspector General (DHHS OIG) list of excluded individuals and entities (LEIE) and the General Services Administration (GSA) System for Award Management (SAM) to ensure that employees are not excluded from participation. The payment ban includes contractors, providers, employees, and suppliers. Searchable lists can be found on the OIG and GSA websites.

## MedStar Select and Medicare Choice Site Evaluations

Site surveys are completed for all MedStar Family Choice PCPs and specialists at the time of initial credentialing and recredentialing. Recredentialing site audits will occur every three years thereafter. If a member complaint is received about the physical condition of the provider office, a follow-up site audit will be performed.

New provider sites and site additions also require a site evaluation after MedStar Family Choice Provider Relations is notified of the change or addition. If you have any questions or comments regarding minimum standards for site evaluations, please contact your provider representative at **800-905-1722, option 5**.

## Covered Preventive Care for MedStar Medicare Choice

Our plan covers many preventive services at no cost to our MedStar Medicare Choice members, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colonoscopy
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Fecal occult blood test
- Flexible sigmoidoscopy
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including flu shots, hepatitis B shots and pneumococcal shots
- Welcome to Medicare preventive visit (one time)
- Yearly wellness visit



Any additional preventive services approved by Medicare during the contract year will be covered.

## Find a Provider - Online Directory

Finding a participating MedStar Family Choice provider couldn't be easier! Visit [MedStarProviderNetwork.org](https://www.MedStarProviderNetwork.org) to look up participating PCPs and specialists by logging on to our online provider directory. Providers can be found by completing one or more of the search fields to get updated information instantly. If your office does not have access to the web, please contact Provider Relations at **800-905-1722, option 5**.

## Use of ABN Not Appropriate for MedStar Medicare Choice

The Advance Beneficiary Notice of Noncoverage (ABN) is a written notice issued to a Medicare beneficiary before furnishing items or services usually covered by Medicare but not expected to be paid in the specific situation. Care is not considered reasonable and necessary, is custodial in nature, or exceeds established therapy caps are common reasons an ABN is issued. The ABN allows the beneficiary to make an informed decision if they want to obtain the service and knowingly accept the expected financial liability. Without this written notice, the member cannot be held financially liable if Medicare denies payment.

Note that use of the ABN is restricted to beneficiaries enrolled in Original Medicare and is not appropriate for members enrolled in a Medicare Advantage Program (MA) or for prescription drugs covered under the Medicare Prescription Drug Program (Part D.)

MedStar Medicare Choice has a process in place for members to request a pre-service/advance organizational determination to confirm if specific services are covered. Prior to rendering services, providers are expected to direct members to request a pre-service organizational determination when he/she believes the item or service may not be covered. A provider is also permitted to request the pre-service organizational determination on behalf of the member. Pre-service organizational determinations should be directed to the Medical Management department at **855-242-4875**.

Additional information on the proper use of the ABN can be found in MLN Article MM7821, the Medicare Claims Processing Manual or directed to Provider Services at **855-222-1042**.

## MedStar Medicare Choice Health and Wellness Education

MedStar Medicare Choice members have access to Silver&Fit, a fitness and healthy aging program designed to help members achieve better health through exercise. The Silver&Fit program includes access to fitness facility membership through a local network of participating fitness facilities, instructor-led classes, home exercise kits, health and wellness educational materials, electronic fitness device tracking and general support.

Silver&Fit can be reached at **877-427-4788**, Monday through Friday, from 8 a.m. to 9 p.m., and can help locate a network fitness center in Washington, D.C., and Maryland, or assist with other program-specific information. TTY users, call, **877-710-2746**. Information is also available on **SilverAndFit.com**. All members are encouraged to talk to their doctor before beginning any new exercise program.

## MedStar Select and MedStar Medicare Choice Provider Appeals Address

Please make sure to submit all provider appeals to the correct address for MedStar Select and MedStar Medicare Choice. The correct address is listed below. Provider appeals sent to the incorrect address could result in the appeal not being received by MedStar Select or MedStar Medicare Choice, or could delay processing.

MedStar Provider Appeals  
PO Box 269  
Pittsburgh, PA 15230  
Fax: **855-435-8762**

## MedStar Medicare Choice Vision Benefit

MedStar Medicare Choice members have their routine vision benefit through Superior Vision. There is a \$0 copay for one routine eye exam per year and \$100 allowance (MedStar Medicare Choice HMO, MedStar Medicare Choice Care Advantage and MedStar Medicare Choice Dual Advantage) toward the cost of one pair of glasses (frames and lenses) or contact lenses every year.

### Diabetes Eye Exam

Diabetes retinopathy is the leading cause of blindness in American adults. Encourage your patients who have diabetes to have their annual dilated eye exam. The diabetes eye exam is of \$0 cost to the patient, which applies to ophthalmologists as well.



## Contact Us

We are here to help. Please reference the below list of numbers if you have any questions or concerns. In some cases, there are separate numbers for MedStar Medicare Choice and MedStar Select.

### Member Services

#### MedStar Medicare Choice

**855-222-1041** PHONE

Seven days a week, 8 a.m. to 8 p.m. (Oct. 1 to Feb. 14)

Monday to Friday, 8 a.m. to 8 p.m. (Feb. 15 to Sept. 30)

Saturday, 8 a.m. to 3 p.m. (Feb. 15 to Sept. 30)

#### MedStar Select

**855-242-4872** PHONE

Monday through Friday, 7 a.m. to 7 p.m.

### Care Management

#### MedStar Medicare Choice and MedStar Select

**888-959-4033** PHONE

Monday through Friday, 8:30 a.m. to 5 p.m.

### Medical Management/Prior Authorization

#### MedStar Medicare Choice and MedStar Select

**855-242-4875** PHONE

Monday through Friday, 8:30 a.m. to 5 p.m.

### Provider Services

(For claims and eligibility inquiries)

#### MedStar Medicare Choice and MedStar Select

**855-222-1042** PHONE

Monday through Friday, 8:30 a.m. to 5 p.m.

### Provider Relations

(For credentialing/re-credentialing or practice additions/terminations/address changes)

#### MedStar Medicare Choice and MedStar Select

**800-905-1722, option 5** PHONE

Monday through Friday, 8:30 a.m. to 5 p.m.

### Interactive Voice Recognition

#### MedStar Select

**855-275-1251** PHONE

To verify member eligibility, access the provider website at **MedStarProviderNetwork.org** or call Provider Services at **855-222-1042**.



**MedStar Health**

5233 King Ave., Suite 400

Baltimore, MD 21237

800-905-1722 **PHONE**

**MedStarProviderNetwork.com**

The MedStar Select and MedStar Medicare Choice Newsletter is a publication of MedStar Health. Submit new items for the next issue to MedStar Family Choice Provider Relations at **mfc-providerrelations2@medstar.net**.

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MedStar Franklin Square Medical Center  
MedStar Georgetown University Hospital  
MedStar Good Samaritan Hospital  
MedStar Harbor Hospital  
MedStar Montgomery Medical Center  
MedStar National Rehabilitation Network  
MedStar Southern Maryland Hospital Center  
MedStar St. Mary's Hospital  
MedStar Union Memorial Hospital  
MedStar Washington Hospital Center  
MedStar Ambulatory Services  
MedStar PromptCare  
MedStar Medical Group  
MedStar Visiting Nurse Association  
MedStar Family Choice  
MedStar Institute for Innovation  
MedStar Health Research Institute