GBMC

FY 2009 Community Benefit Report Supplemental Narrative

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

	FY 2009 Licensed Beds
Medical-Surgical Acute	145
Gynecologic (GYN)	27
Definitive Observation/Stepdown	34
Medical Surgical Intensive Care	24
Medical Cardiac Critical Care	12
Total Medical-Surgical Acute Care	242
Other	
Obstetric (OB)	60
Pediatric	8
Licensed Bed Capacity	310
Newborn Nursery	60
Neonatal Intensive Care	30
Skilled Nursing Facility	25

	FY 2009 Inpatient Admissions
Med-Surg Acute/OB/Pediatric	25,817
Skilled Nursing Facility	649

2. Describe the community your organization serves.

    a) See attached Powerpoint file titled “Supplemental Question 2-GBMC”.

Supplemental Question#2

Information Regarding the Community Served
by Greater Baltimore Medical Center

GBMC's & It's Community

- **Greater Baltimore Medical Center, Inc. ("GBMC") is a private, not-for-profit, 310-bed, regional medical center.**

- **Located in Towson, Maryland, a suburban Baltimore County community two miles north of Baltimore City.**

- **GBMC's primary service area includes all of Baltimore County, the northern portion of Baltimore City, and portions of Carroll and Harford Counties.**

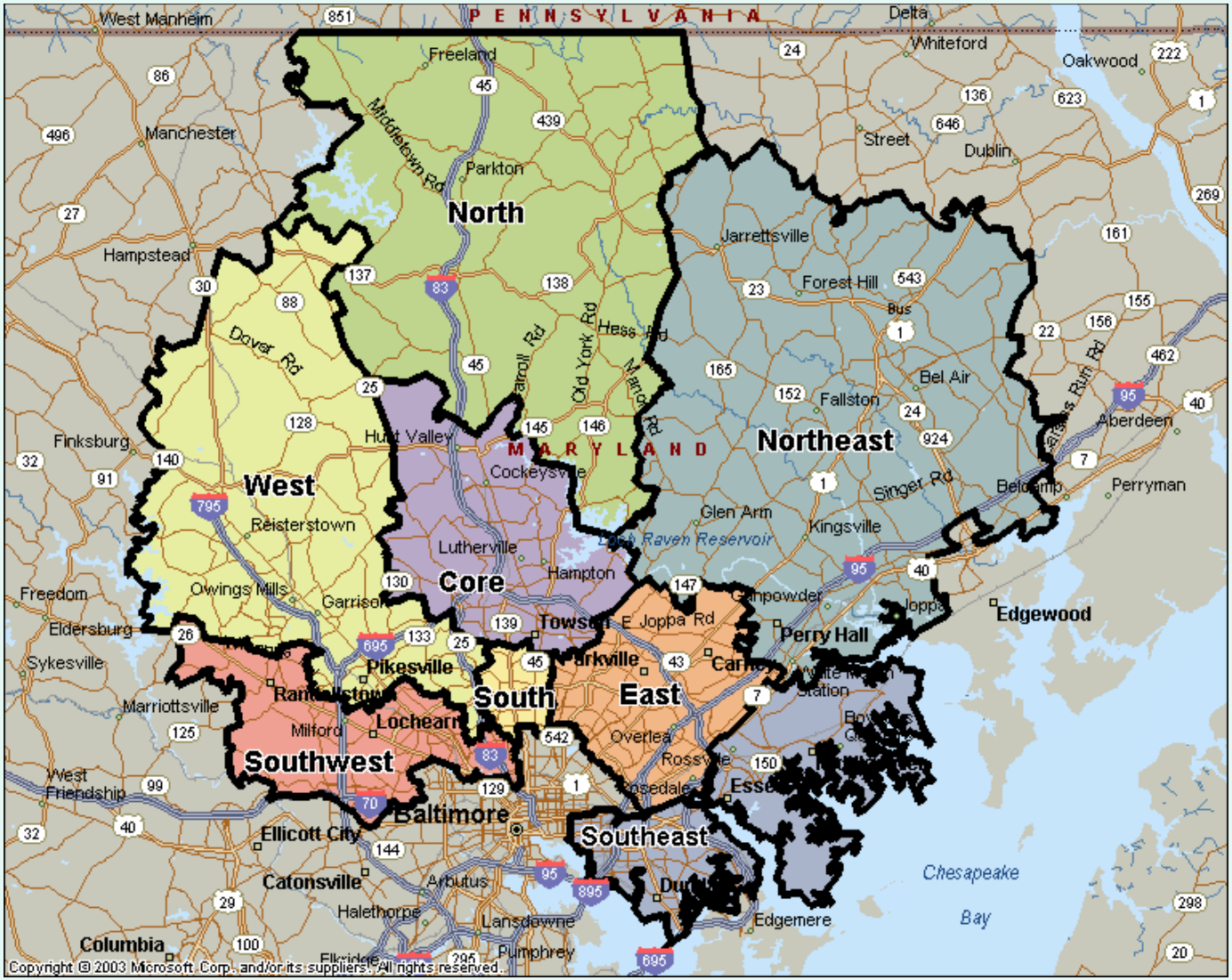
- **In 2008, Baltimore County had an estimated population of 785,618.**

- **The population in GBMC's service area has traditionally been affluent.**
  - -Baltimore County ranked 2nd among MD counties for the highest income per capita in 2007.
  - -The 2007 per capita income in Baltimore County was 34% high than the nation.
  - - But,in 2007 Baltimore County had:
    - 8% of the population in poverty
    - 9% of related children under 18 were below the poverty level
    - 8% of people 65+ years old were below the poverty line
    - 5% of all families lived in poverty
    - 14 % of families with a female householder and no husband present had incomes below the poverty level

- **In FY 2009GBMC's service area patients were 1.47% self-pay and 5.26% Medicaid.**

- **GBMC's patients in FY 2009, were 1.9% self-pay and 5.1% Medicaid.**

GBMC Eight Market Zones



MD Healthcare Commission

TABLE 1: Health Insurance Coverage of the Nonelderly, 2006–2007

			Percent Distribution by Coverage Type[b]			
		Nonelderly (in Thousands*)	Employment-based	Direct-purchase	Medicaid & Other Public	Uninsured
Total Nonelderly[a]		**4,940**	**69**	**5**	**11**	**15**
Age						
	Children—Total	1,460	65	4	20	10
	Adults—Total	3,480	71	5	7	17
	Adults 19–24	500	54	10	7	29
	Adults 25–29	350	58	3	8	31
	Adults 30–34	330	74	4	5	17
	Adults 35–44	820	73	4	6	17
	Adults 45–54	850	77	4	7	12
	Adults 55–64	630	78	4	10	8
Gender						
	Female	2,500	70	5	11	14
	Male	2,430	68	4	11	17
Annual Family Income[c]						
	Up to $30,851	860	27	5	31	37
	$30,852–$60,208	1,060	64	6	12	18
	$60,209–$104,546	1,370	77	5	7	12
	$104,547+	1,650	87	4	3	6

NOTE:
This survey focuses on Maryland's nonelderly (under age 65) population because nearly all of the elderly are covered by Medicare.

MD Healthcare Commission

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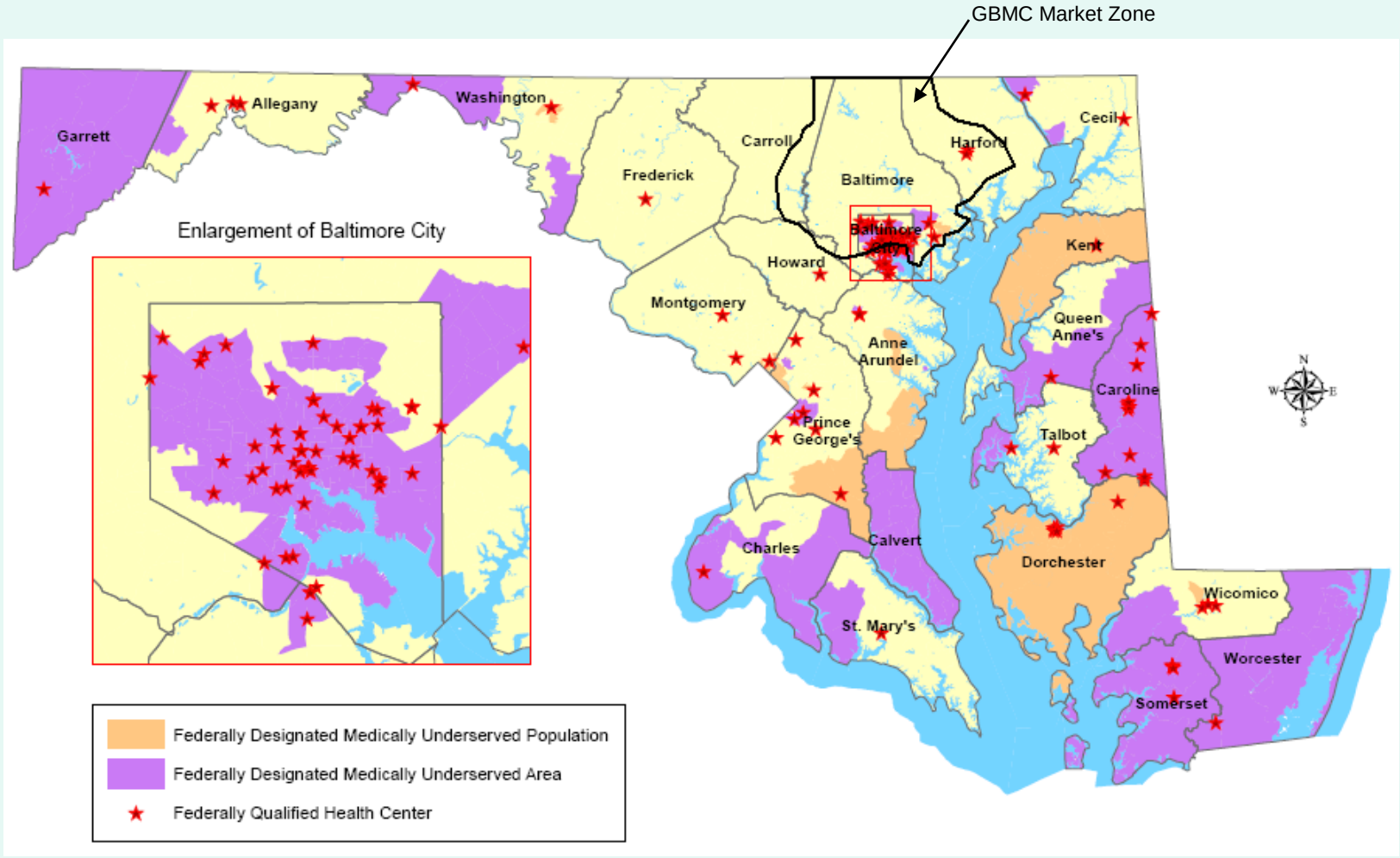
	Nonelderly (in Thousands*)	Employment-based	Direct-purchase	Medicaid & Other Public	Uninsured
Total Nonelderly[a]	**4,940**	**69**	**5**	**11**	**15**
Family Poverty Level[d]					
Poor (≤100%)	430	17	4	43	37
Near Poor (101% to 200%)	520	38	4	24	34
Low Moderate (201% to 300%)	700	59	5	13	23
Mid Moderate (301% to 400%)	720	69	6	8	17
High Moderate (401% to 600%)	1,110	83	5	5	8
High (601%+)	1,450	90	3	2	4
Family Work Status[e]					
3+ Full-time Adult Workers	240	71	1	4	23
2 Full-time Adult Workers	1,480	82	3	4	10
1 Full-time Adult Worker	2,440	72	5	9	15
Only Part-time Adult Worker(s)	140	41	12	23	24
Only Part-year Adult Worker(s)	330	43	8	26	23
No Adult Workers	310	21	5	44	30
Highest Educational Level of Adults in Family					
No High School Diploma	290	28	3	23	46
High School Graduate Only	1,060	50	4	20	25
Assoc. Degree/Some College	1,250	69	6	11	13
BA/BS Degree	1,180	79	5	6	10
Graduate Degree	1,160	86	4	4	6
Race/Ethnicity[f]					
White, Non-Hispanic	2,740	78	5	8	9
Black, Non-Hispanic	1,490	60	4	18	18
Hispanic (Any Race)	400	41	3	10	46
Asian/Other, Non-Hispanic	300	74	4	7	16

NOTE:
This survey focuses on Maryland's nonelderly (under age 65) population because nearly all of the elderly are covered by Medicare.

Maryland Medically Underserved



GBMC
FY08 / 09 Revenue
Sub-Total Self Pay / Medicaid

Primary Insurance Group	FY08 Total Gross Rev	% Total	FY09 Total Gross Rev	% Total
Self Pay	7,295,615		7,744,250	
Medicaid	4,702,969		6,711,416	
Medicaid Pending	1,503,843		1,874,609	
MCO	9,646,704		12,147,287	
Sub Total:	**23,149,132**	**6.3%**	**28,477,562**	**7.0%**
Other	**346,825,971**	**93.7%**	**375,810,436**	**93.0%**
Total:	**369,975,103**	**100.0%**	**404,287,998**	**100.0%**

3. Identification of community needs:

    a) Describe the process used by your hospital for the health needs in your community, including the date when most recently compiled.

    During fiscal year 2006 the Greater Baltimore Medical Center (GBMC) Community Needs Advisory Committee compiled a GAP assessment designed to evaluate and understand the unmet healthcare needs of the GBMC community, and how GBMC, given its service orientation, might be best served to assist in meeting the identified unmet needs.

    Because Baltimore County has not prepared a formal community needs assessment, GBMC borrowed statistical and medical incidence data from the 2004 Carroll County community needs assessment, as well as various other national data.

    b) In seeking information regarding community health needs, did you consult the local health department?

    During preparation of the GAP assessment, GBMC contacted the Baltimore County department of health regarding the use of a county-wide needs assessment and was informed that the county did not compile such an assessment. However, GBMC, in order to update the fiscal year 2006 GAP assessment, recently met with the Baltimore County Department of Health and Department of Aging. While a formal community needs assessment is still not prepared for the county, statistical incidence information on select disease categories can be provided by the County Health Department. The purpose of the meeting is to establish a cooperative relationship with the County Health Department and seek information to ensure that GBMC's community initiatives are focused on areas of unmet community need.

4. Please list the major needs identified through the process explained in question #3.

    a) Obesity/Weight-Management – focuses on growing incidence of inactive lifestyles and diet management, which when not managed properly lead to significant increases in diabetes, obesity and other health related issues.

    b) Obstetrics/Gynecology – centers primarily on the sexual behavior of adolescents and associated teenage pregnancy rates.

    c) Geriatrics – addresses the increasing percentage of the population aged 65 years and older, including the increased percentage living at or below federal poverty guidelines. This particular population is challenged

regarding access to primary care services due to transportation as well as health related issues. By not properly accessing care at a primary, or preventive stage, this population often presents to healthcare providers with advanced disease conditions.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

    - GBMC maintains a inter-disciplinary Community Needs Advisory Committee, with representation from Outreach Services, Compliance, Finance, Legal and other clinic based areas, which meets monthly to evaluate, debate and approve community based initiatives. In addition, the Committee reports directly to the President & Chief Executive Officer and also maintains two Board members as members of the Committee.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

    a) Geriatric Nurse Practitioner – GBMC hired a nurse practitioner whose sole responsibility is to provide education and primary care services (physical history, medication management assistance, blood pressure screenings and seasonal vaccinations) at Towson area low-income senior living facilities. This was a service that had at one-time been provided by Baltimore County, but was discontinued a number of years ago.

    b) American Diabetes Association (ADA) Partnership – Over the last three years GBMC has contributed $50,000 to the ADA Youth II diabetes initiative. The program is designed to enroll qualifying participants in targeted geographic regions of Baltimore County and Baltimore City. Once enrolled, the participants are provided information and access to resources designed to improve daily routines, specifically diet and exercise.

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major community benefit program initiatives.

    - The recent major initiatives undertaken by GBMC and described in the answer to question #6 have not yet been evaluated. Specifically, it was recognized that each of these programs would take a period of time to build volume and start to incur measurable and quantifiable results. Nonetheless, an element of each initiative is the tracking of encounter data, and in the case of the Geriatric Nurse Practitioner the type of services provided, to evaluate the effectiveness of each program to determine if continued funding is desirable.

8. Provide a written description of gaps in availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

    - As noted in previous years, GBMC continues to experience difficulty in providing anesthesia, obstetrical, and orthopedic services to Medicaid and uninsured patient populations.

9. If you list physician subsidies in your data, please provide detail.

    - GBMC owns and operates a physician practice that is committing to ensuring all patients have appropriate access to OB/GYN care. Accordingly, the practice operates with an annual loss due primarily to its provision of care to medically underserved patients. The annual operating loss is claimed as a community benefit.

Appendix 1

GBMC

FY 2009 Community Benefit Report Filing
Description of Financial Assistance Policy

GBMC has taken significant measures to ensure that its Financial Assistance Policy is both visible and accessible to patients by enacting the following measures:

1. Availability of Applications & Brochures

- Via website
- All hospital patient registration areas; including admitting, emergency department, laboratory stations, clinics and radiology services
- GBMC owned physician offices
- Billing Office
- Included in each billing statement to patient

In addition, to the availability of applications and brochures, signs describing the existence of a Financial Assistance Policy and opportunity for financial assistance are also prominently displayed throughout the hospital.

2. Direct Assistance

Utilizing the admitting and insurance verification process, prior to discharge, the Patient Financial Services department attempts to assist many patients with financial evaluations in order to determine the availability for financial assistance and/or qualifying insurance coverage. In addition, during the account resolution process, staff is also trained to evaluate a patient's unique circumstances and attempt to direct patients to financial assistance when appropriate.

GBMC will also assist patients in enrolling for State Medical Assistance coverage.

3. Education

To ensure that employees are qualified to direct patients in accessing financial assistance, new employees and volunteers are specifically educated during new-hire orientation programs on how to obtain financial assistance applications and brochures.

Appendix 2

Greater Baltimore Medical Center
Patient Financial Assistance Services
Financial Assistance Policy

I. PURPOSE

To establish guidelines assuring consistency in the implementation of the Financial Assistance Program.

II. POLICY

GBMC recognizes its obligation to the communities it serves to provide medically necessary care to individuals who are unable to pay for medical services regardless of race, color, creed, religion, gender, national origin, age, marital status, family status, handicap, military status, or other discriminatory factors.

The Financial Assistance procedures are designed to assist uninsured individuals or individuals who qualify for less than full coverage under federal, state or local programs, or individuals whose patient balances after insurance exceed their ability to pay.

While flexibility in applying guidelines to an individual patient's situation is clearly needed, certain objective criteria are essential to assure consistency in the implementation of the Financial Assistance Program.

A. Eligible/Ineligible Services

1. Services considered medically necessary are covered under the program

2. Services considered elective (i.e. cosmetic) are not covered under the program unless directly to related or part of a medically necessary procedure

3. Applicants meeting eligibility criteria for Federal Medicaid must apply and be determined ineligible prior to Financial Assistance consideration

B. Referral Sources

1. Financial Assistance referrals will generally originate in the Insurance Verification, Advocacy and Collection/Insurance departments accompanied with a **Financial Evaluation** (Attachment #1) and **Medical Assistance Eligibility Check List** (Attachment #1a)

2. Other referral sources include social services, physician offices, administration, etc.

3. GBMC recognizes the importance of communicating the availability of the

Financial Assistance Program to all patients

a. The Financial Assistance Application and brochures explaining the program are located on the GBMC website

b. Brochures and applications are available in all GBMC owned physician offices and in all hospital registration areas

c. All new employees and volunteers are educated during their orientation programs with regard to the Financial Assistance Program and how to assist patients in obtaining applications and brochures

C. Financial Eligibility Criteria

1. Eligibility is based on gross household income

2. Gross household income is defined as wages and salaries from all sources before deductions

3. Other financial information such as liquid assets and liabilities are considered

4. Annual household income criteria is 300% of the current poverty guidelines published in the Federal Register

5. Applicants that exceed established household income levels may still be eligible when additional factors such as disposable net income are considered (See "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines")

D. Household Income

1. Household Income to be considered

a. All wages and salaries

b. Social Security, veteran's benefits, pension plans, unemployment and worker's compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest and dividends or other regular support from any person living in the home

c. Generally, the availability of liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc. exceeding 2 months of living expenses will be considered (referred to in the policy as Liquid Assets)

d. Based on individual circumstances, allowances can be made to have liquid assets exceed the two month test up to $25,000

2. Proof of Household Income (Attachment #2)

a. One or more of the following items may be requested from the applicant to verify income for each income producing member of the household. Monthly household income is prorated to determine annual household income level.

b. Two recent pay stubs reflecting year-to-date earnings for each family member who is a guarantor or could be deemed responsible for the account.

c. Most recent income tax return(s) with W2s

d. Social Security Award Letter(s)

e. Most recent unemployment insurance stub

f. Two most recent checking and savings account statements

g. Two most recent investment statements (money market, CD, stocks, etc.)

h. Letter from federal, state or local agency verifying the amount of assistance awarded

i. Applicants claiming zero household income must supply proof of how their living expenses are paid with a notarized letter of support. Cancelled checks and/or receipts may also be required if another individual is paying patient's bills

j. Medical Assistance denial or spend-down determination letter

k. Identified asset transfers within a 12 month period of application may be factored into determining eligibility.

l. Other pertinent household income verification documentation as required

E. Expenses

1. Expenses to be considered (also see "Questionable Expenses" under "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines")

2. All reasonable living expenses (mortgage/rent, utilities and loan/credit card payments)

    a. Either land-line telephone or cell phone bill will be considered (not both)

    c. A monthly car payment of up to $450 for one car is allowed
    The maximum allowance per family (2 adults) is $900
    Any amount over the above allowance will be considered within the miscellaneous allowance

    d. Payments for recreational items such as boats, motorcycles, etc. are not allowable expenses Exception: if motorcycle is only source of transportation

    e. Expenses for Cable TV, Dish TV and/or Internet are considered within the miscellaneous allowance

    f. Expenses for second homes are not allowable expenses (however, income from rental properties will be counted as Household Income)

    g. $150 food allowance will be given for patient; and $75 food allowance for each additional family member

    h. $300 miscellaneous allowance will be given for ancillary living expenses (i.e.: gas for automobile, grooming items, automobile maintenance, tuition and tithing)

3. Medical expenses

    1. Up to $100 in prescription expenses per person will be considered without receipts

    2. Prescription expenses that exceed $100 per person cannot be considered unless patient provides receipts for the two prior months

    3. Medical expenses are considered upon proof from patient of active payment arrangements

III. PROCEDURES

A. Application Process

1. Patients may request Financial Assistance prior to treatment or after billing

    a. A new application must be completed for each new course of treatment with the following exceptions:

Inpatient and outpatient Medicare patients are certified for one year (see "Medicare Patients")

Inpatient and outpatient non-Medicare patients are certified for 6 months. However, if it is determined during the course of that period that the patient meets Medical Assistance eligibility criteria they are required to pursue Medicaid prior to receiving additional Financial Assistance

Mitigating circumstances impacting eligibility period are identified. (examples include favorable changes in the applicants income, winning a lottery, receiving notable inheritance, etc..) These determinations are made at the discretion of the Collection Manager and/or Director of Patient Financial Services.

3. At the time of application all open accounts are eligible for consideration with the potential exception of patients who are in bad debt status and did not respond to collection activity or statements prior to write-off of account(s)

4. The signed/completed **Financial Evaluation** is referred to the Financial Assistance Department

   a. Combined account balance(s) greater that $2,500

      1. Completed **Financial Evaluation**

      2. Proof of household income

      3. Credit bureau report obtained and reviewed to verify information, develop additional sources for funds and utilized as a collection tool found

   b. Combined account balance(s) less than $2,500

      1. Completed **Financial Evaluation**

      2. Proof of household income

      3. Credit bureau report may be obtained and reviewed if household income and/or household expense discrepancies are found

   c. Accounts are approved or denied based on household income criteria and applicant cooperation

B. Household Income Criteria for Financial Assistance Approval / Denial

1. Combined gross household income less than 300% of the poverty guidelines

    a. Applicants are eligible for 100% Financial Assistance

    b. However, applicants with liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc., not exceeding $25,000, who meet the income eligibility requirements, will be considered for assistance at the discretion of the Director of Patient Financial Services and/or the Financial Assistance Committee. Inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for assistance.

    c. Applicants with liquid assets (described above) exceeding $25,000, may not qualify for assistance. However, at the discretion of the Chief Financial Officer, inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for full or partial assistance

2. Combined gross household income greater than 300% of the poverty guidelines and the patient is still unable to make acceptable payment arrangements (minimum - $25 per month)

    a. Applicants are reviewed on a case-by-case basis (see "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines")

C. Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines

1. Applicants whose gross household income exceeds 300% of the poverty guidelines but state they are still unable to pay all or part of their account balance(s) may be further evaluated for Financial Assistance

2. In these cases, consideration is given to expenses, disposable net household income, total liquid assets and account balance(s)

3. Disposable net income is defined as gross household income less deductions and expenses (Program allows $250 disposable income for one person and $75 for each additional family member.) Disposable income (exceeding $250 for one person and $75 for each additional family member) will be used to determine patient's ability to pay)

    a. The applicant is required to supply proof of "questionable" expenses

        1. "Questionable" expenses are defined as any expense item that appears to be overstated/understated and/or not reasonable or

customary

b. A credit bureau report is required to evaluate the application (regardless of account balance)

c. Patients whose disposable income is within the limits stated above and whose liquid assets do not exceed the standard (See Household Income); are eligible for 100% Financial Assistance

d. Patients who exceed the asset standard (See Household Income) are ineligible for Financial Assistance and need to make payment arrangements (See Resource Payment Arrangements)

e. Eligibility for patients who have excess disposable income is determined based on ability to satisfy outstanding balance(s) within timeframe defined (See Financial Assistance With Resource) All exceptions will be reviewed by the Director of Patient Financial Services

4. Applicants approved for 100% Financial Assistance (See "Processing Approved Applications")

D. Financial Assistance With Resource

1. Resource amounts are determined based on the applicant's ability to pay a portion of their account balance(s) without causing undue financial hardship \ using the following guidelines

2. Outstanding balance(s) owed to GBMC are divided by excess disposable income to determine the number of months needed to pay the outstanding balance(s) in full

3. Excess disposable income determines the amount of the monthly payment (See Resource Payment Arrangements for standards)

4. Outstanding balance(s) that cannot be satisfied within 24 months will be reduced by the difference between the total outstanding balance(s) and the total required patient payment amount (excess disposable income multiplied times 24 months)

5. All resource amounts are reviewed and approved by the Director and Collection Manager

6. Approval process

a. The completed **Financial Evaluation** (including resource recommendation), **Authorization Form** (Attachment #3) and documentation is forwarded to the Collection Manager

b. The Collection Manager will ensure that all required authorization signatures are obtained

7. When authorization is obtained the patient is mailed a **Financial Assistance Reduction Letter** (Attachment #6) and a **Financial Assistance Promissory Note** (Attachment #6A) outlining the terms and conditions of the agreement

8. The **Financial Assistance Promissory Note** must be returned within 14 days. Failure to do so may result in the patient's ineligibility for Financial Assistance

a. Signed promissory notes are forwarded to the Collection Manager (see "Processing Approved Applications")

E. Resource Payment Arrangements

1. Resource payment arrangements will not exceed 24 months

a. Every effort is made to liquidate the resource amount within the earliest possible time frame

2. The minimum monthly payment amount is $25

a. Patient is set up under a contract in Meditech with an alert on Patient Overview screen (alert is set to remind collector that partial write-off occurred in the event of patient default on resource payments)

b. Patients are automatically sent monthly statements through Meditech indicating their monthly payment amount, due date and account balance(s)

4. If a patient qualifies for Financial Assistance with a resource and has multiple account balances, all account balances are allowanced leaving only one open account (if possible) for the resource amount

a. A weekly Meditech work list is reviewed to determine if patients are delinquent with their payments

b. Failure to pay as agreed will result in the patient being responsible for both the allowance amount and the unpaid resource balance

c. Forward the delinquent account to the Collection Manager

d. The Collection Manager/ or designee reverses the Financial Assistance allowance

e. Patient is sent a final demand letter

F. Authorization For Financial Assistance

$1 - 2,499	- Coordinator
$2,500 - 5,000	- Collection Manager
$5,001 - 10,000	- Director of Patient Financial Services
GT $10,000	- EVP/CFO

G. Incomplete / Uncooperative

1. Failure to supply required information or to communicate reason for delay within 10 days may result in the applicant's ineligibility for Financial Assistance

H. Processing Approved Applications

1. Completed applications are forwarded to the Collection Manager with all appropriate supporting documentation

2. The Collection Manager will ensure that each applicant has met household income requirements, supplied appropriate supporting documentation and that proper authorization signatures are obtained

    a. The Collection Manager or designee applies the Financial Assistance adjustment and files the **Financial Evaluation**, **Authorization Form** and related documentation

3. The patient is sent a Financial Assistance Award Letter (Attachment #4)

I. Processing Denied Applications

1. Applicants that are determined to be ineligible based on household income and/or asset criteria are sent a Financial Assistance Denial Letter Attachment #5)

2. Patients have the right to appeal denials. Final appeal decisions are at the sole discretion of the next level of required signature authority. (Example – Director of Patient Financial Services to review appeal for Collection Manager level denial)

J. Medicare Patients

1. Medicare patients are required to supply a copy of their Social Security Award Letter on a yearly basis

2. Medicare patients are certified for 1 year. However, if it is determined during the course of that year that the patient meets Medical Assistance eligibility criteria they will be required to pursue Medicaid prior to receiving additional Financial Assistance

3. The Financial Assistance Department will refer Medicare patients meeting Medicaid eligibility criteria to the Advocacy Department for processing

K. Medicaid Resources

1. Medicaid resources are automatically reviewed for Financial Assistance when a copy of the Department of Social Services (DSS) **0102 Form** (Attachment #7) is supplied to the Financial Assistance Department

2. DSS income calculations and Financial Assistance program allowances are used to calculate patient's disposable income (see "Gross Household Income Is Greater Than 300% Poverty Guidelines")

L. Recurring Accounts

1. Patients are certified 6 months for Non Medicare and 1 year for Medicare. Based on each unique situation, these periods may be extended at the discretion of the Director of Patient Financial Services.

2. If patients are admitted or start a new course of treatment, they are screened for Medicaid and/or reevaluated for Financial Assistance

M. Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

IV. ASSUMPTIVE FINANCIAL ASSISTANCE

Assumptive Financial Assistance is a program run in partnership with TransUnion credit reporting agency. Self-pay Emergency Department cases are referred to TransUnion, who utilizes a proprietary credit scoring system to determine likelihood of ability to pay based on estimated income and family size. The results from the TransUnion credit scoring are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection.

A. Eligible/Ineligible Services

1. Only bills for uninsured patients for services incurred in the Emergency Department are eligible for Assumptive Financial Assistance screening at this time

2. Patients seen in the Emergency Department as the result of a motor vehicle accident or for which any third party liability may exist will not be considered under the Assumptive Financial Assistance program

3. Uninsured patients seen in the Emergency Department under Emergency Petition will not be condisered under the Assumptive Financial Assistance program until the Maryland Medicaid Psych program (MAPS) has been billed

V. PROCESSES UTILIZED BY TRANSUNION TO DETERMINE ELIGIBILITY STATUS

A. TransUnion accesses credit data, via the Healthcare Revenue Cycle Platform (HRCP). TransUnion built and maintains a proprietary matching algorithm to select consumer credit files, including data like; name, address, SSN, Soundex and other criteria to match input inquiries to the correct credit file. This algorithm is used to match hundreds of millions of credit inquiry requests each year. It is constantly reviewed and maintained to provide accurate credit data to tens of thousands of customers. The minimum customer input requirement is name and \ address. TransUnion also accepts, SSN, previous address and date of birth input as part of its matching algorithm. HRCP then employs proprietary algorithms and expert business rules to match each hospital's own charitable, regulatory guidelines and policies to patient qualifications.

B. HRCP employs a proprietary algorithm to estimate minimum family income and size. The algorithm uses information like debt to income ratios, current financial obligations that are being met, residual income for household members and cost of living calculations to estimate the minimum monthly income. HRCP also estimates family size based upon data such as, joint credit accounts, authorized users of credit cards, etc. The algorithm calculates FPL based upon these data. Customers may evaluate and configure certain parts of the algorithm like residual income to level the estimates for cost of living differences in geographic areas.

C. Under the Fair Credit Reporting Act (FCRA) and other privacy regulations, TransUnion cannot disclose financial information regarding individual consumers to anyone without satisfying permissible purpose requirements.

D. The HRCP proprietary algorithm used for estimating FPL (minimum estimated family income and size) uses both credit data and other calculations like residual income and cost of living. In the absence of credit data, other calculations are used and can be configured to consider certain geographic cost of living differences as

stated above. In such instances where credit data is absent, it is recommended to further qualify FPL if possible through documentation or patient interviews.

VI. ASSUMPTIVE FINANCIAL ASSISTANCE PROCEDURES

A. Identifying Patients For Assumptive Financial Assistance Write-offs

1. Up to three invoices per Emergency Room visit will be sent to each uninsured patient for hospital charges incurred. In addition, at least one phone call will be generated to the patient by the Patient Liability Staff.

2. Patient Financial Services may accelerate the screening process based on individual patient experience or accumulated historical data.

3. The invoices will be generated at the time of final billing of the patient's account and then 30 days from initial billing and then 60 days from intial billing

4. Within 10 days after the final invoice has generated, a file will be created to identify all accounts that have remained in a self pay status (excluding motor vehicle accidents, emergency petitions, and other third party liability)

5. The file will be sent to TransUnion for credit scoring **(see VI. on page 12 for Processes Used By TranUnion To Determine Eligibility Status)**

6. TransUnion will return the file with the credit scoring for each individual

   a. **Meets Charity Guidelines** means the patient income is below 300% of the Federal Poverty Guidelines and the patient does not have the ability to pay. The patient qualifies for a write off of their Emergency Room bill under the Assumptive Financial Assistance write off code (CHAASSUMP) in Meditech.

   b. Collect Hospital Charges, Pursue Payment Arrangement or Question Household Income means the patient appears to have the ability to pay and the Patient Liability staff will pursue a payment plan or offer Financial Assistance Screening through our non-assumptive program

   c. **No Credit Found** means the patient demographic information did not match any information in the TransUnion data bank. The Patient Liability staff will pursue the patient and if additional or corrected demographic information is uncovered, they will have the patient rescreened through TransUnion.

d. **Social Security Number not issued by Social Security** Administration or Social Security Number used in death benefits requires that we pursue patient. If the Patient Liability staff uncovers a data entry error with regard to Social Security Number they will have the patient rescreened through Trans Union.

B. Reversal Of Assumptive Financial Assistance Write-offs

1. If verifiable insurance is uncovered at anytime after the Assumptive Financial Assistance write-off, the write-off will be reversed and the patient's insurance billed

C. Assumptive Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

Review Cycle: Annual

Approved By: Eric Melchior,
Executive Vice-President and CFO
July 2009

Appendix 3/4

FY 2009 Community Benefit Report Filing
Mission, Vision & Values Statement

MISSION

Health. Healing. Hope.

The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope.

VISION

Medical Sophistication with Personalized Service.

The vision of GBMC is to be the preferred medical center in Maryland for the best physicians, nurses and staff by providing medical sophistication with personalized service, enhanced by clinical education and research with the guiding principle that *"the patient always comes first."*

GREATER VALUES

The values of GBMC are our GREATER Values of Respect, Excellence, Accountability, Teamwork, Ethical Behavior and Results.