GBMC

FY 2011 Community Benefit Report Supplemental Narrative

I. General Hospital Demographics & Characteristics

Table 1

A. Bed Designation

	FY 2011 Licensed Beds
Medical-Surgical Acute	121
Gynecologic (GYN)	18
Definitive Observation/Stepdown	42
Medical Surgical Intensive Care	24
Medical Cardiac Critical Care	12
Total Medical-Surgical Acute Care	217
Obstetric (OB)	60
Pediatric	8
Licensed Acute-Care Bed Capacity	285
Other Bed Designations	
Newborn Nursery	60
Neonatal Intensive Care	30
	25

B. Inpatient Admissions

Med-Surg Acute/OB/Pediatric (includes 4,372 births)	23,693
Skilled Nursing Facility	583

C. Primary Service Area Zip-Codes

Rank (based on inpatient discharges)	Zip-Code
1	21093
2	21234
3	21117
4	21030
5	21204
6	21286
7	21212
8	21236
9	21206
10	21136
11	21221
12	21208
13	21209
14	21222
15	21239
16	21207
17	21220
18	21215
19	21218
20	21237
21	21214
22	21133
23	21244

D. Other Maryland Hospitals Sharing Primary Service Area

- St. Joseph Medical Center
- Sinai Hospital
- Franklin Square Hospital
- Good Samaritan Hospital
- Union Memorial Hospital
- Mercy Medical Center
- Norwest Hospital Center

E. Uninsured/Medicaid Recipients

GBMC's primary service area is strongly linked to Baltimore County and a small area of Northern Baltimore City, Carroll and Harford counties. Our most recent analysis identified that GBMC's service area had a population of uninsured equal to 1.47% and Medicaid population equal to 5.26% (We believe listing the uninsured and Medicaid populations by each distinct area, specifically Baltimore City, from which GBMC receives patients would inaccurately state the uninsured/Medicaid population of GBMC's primary service area).

Table 2: Describe the Community your Organization Serves

See attached file titled "Supplemental Question #2"

II. Community Health Needs Assessment

1. Identification of Community Health Needs:
   Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

   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.

   Currently GBMC is partnering with several local healthcare providers to have a Community Needs Assessment prepared.

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

   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.

3. When was the most recent needs identification process or community health needs assessment completed?
   Provide date here. __/__/__ (mm/dd/yy)

4. Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?
___Yes
X No

If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Does your hospital have a CB strategic plan?

X Yes (GAP Assessment used as a basis for selecting certain CB initiatives)
___No

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

i. Senior Leadership

1. X CEO
2. ___CFO
3. ___Other (please specify)

ii. Clinical Leadership

1. ___Physician
2. ___Nurse
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. ___Individual (please specify FTE)
2. X Committee (please list members)
   - Michael Myers – Director of Finance
   - Stacey McGreevy – Chief Audit Executive Compliance
   - Susan Martielli – General Counsel

- Kimberly Davenport – Community Relations & Events Manager
- Joe Hart – Chaplan, Spiritual Support Director

3. ___Other (please describe)

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

Spreadsheet	X	yes	_____	no
Narrative	X	yes	_____	no

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

Spreadsheet	_____	yes	X	no
Narrative	_____	yes	X	no

IV. Hospital Community Benefit Program & Initiatives (see attached Table III)

V. PHYSICIANS

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

- GBMC continues to fund anesthesia, obstetrical, and orthopedic services to Medicaid and uninsured patient populations. GBMC has generally covered this by agreeing to provide physician payment for surgical cases coming through the emergency department where the patient is considered to be indigent.

Table III

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Access to Primary Care Services for Low Income Seniors	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.	Multi-Year		Monitored annually to review the continued demand/volume of services delivered	Believe this has proven an invaluable service to the community members being served	Plans are to continue the initiative

Table III

Initiative 2.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Primary Care Needs for "at-Risk" Adolescents	Adolescent Pediatrician	Operated by Catholic Charities, the Villa Maria and St. Vincent's Centers in Timonium offer residential mental health treatment for nearly 160 children between the ages of 5 to 14. Owing to a variety of complex socio-economic issues, this highly at-risk population tends to have a variety of associated medical conditions. GBMC has provided a Pediatrician to the centers in order to provide primary care assessments and treatment, review medical reports and coordinate specialized care and dietary needs as necessary and preventive care.	Multi-Year	Catholic Charities		Believe the objective of provided primary care services is being fulfilled as needed.	Plans are to continue the initiative

Table III

Initiative 3.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Adolescent Diabetes	Youth II Reverse the Trend	Over the last four years GBMC has contributed $65,000 to the American Diabetes Association Youth II diabetes initiative. The program works with Head Start programs at area YMCA's to educate families regarding appropriate healthy lifestyles and the risk of Type II diabetes in adolescents.	Multi-Year	American Diabetes Association	Updates provided annually by the ADA	Quantified measurable results are hard to determine given that the program strives to raise awareness in order to curb, or prevent, incidence of diabetes. It is believed education at an early point in life while enrolled in programs such as Head Start can have a lasting and lifelong impact on individuals.	No commitment made at this time for continued participation

Table III

Initiative 4.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Stroke Rehab	YOGA for Stoke Survivors	Provides a quarterly YOGA program through certified instructors that allow patients to continue rehab after typical initial rehab sessions covered by insurance are exhausted	Multi-Year		Relatively new program that will be evaluated annually	Believe the program has allowed patients to realize additional range-of-motion and other rehab benefits not ordinarily achieved through normally required stroke rehab.	Plans are to continue the initiative

Table III

Initiative 5.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative

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, 285-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.**

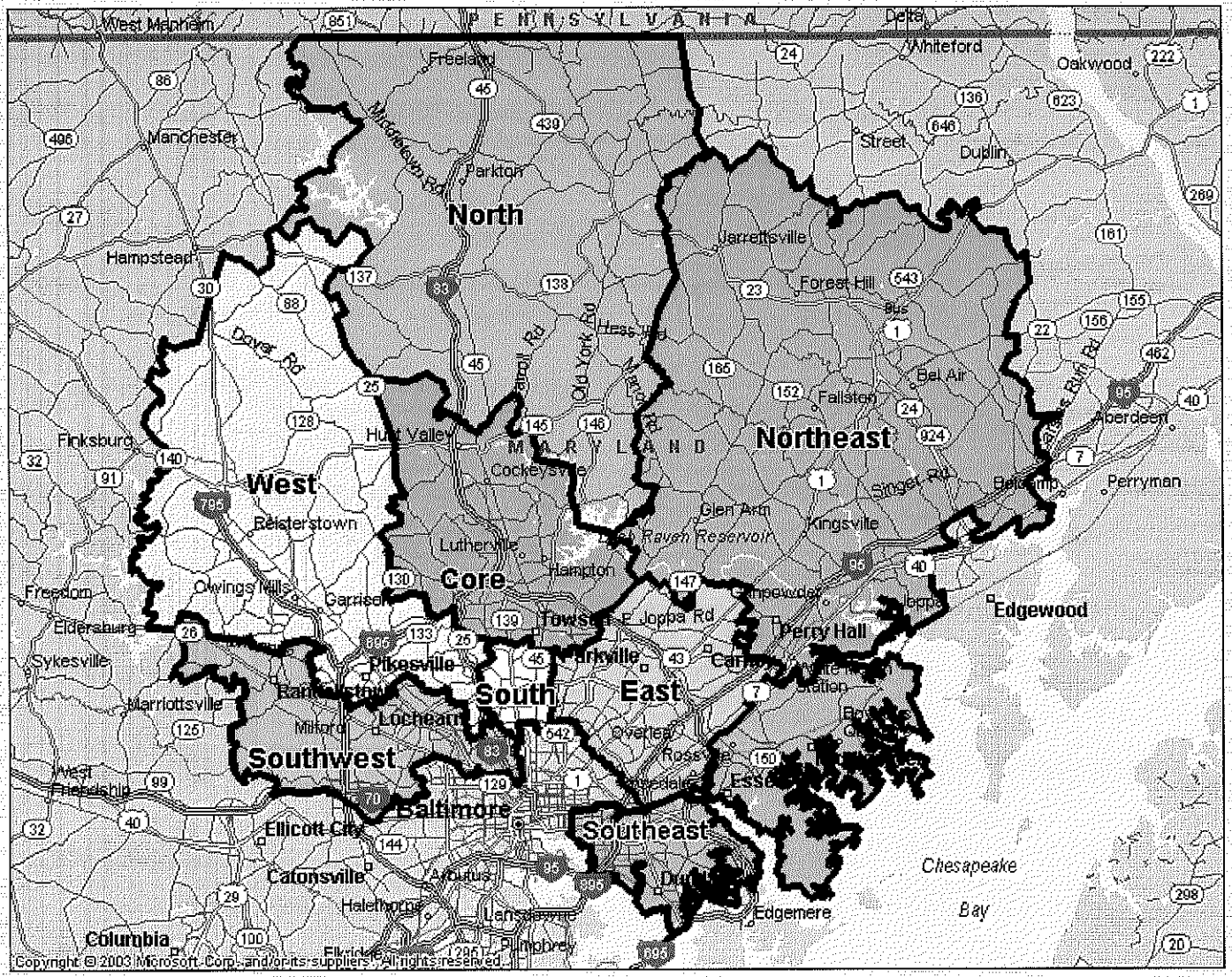
- **In 2010, Baltimore County had an estimated population of 805,029.**

- **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.
  - - In 2009 Baltimore County had a poverty level of 8.3%:

- **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



Baltimore County, Maryland

People QuickFacts	Baltimore County	Maryland
Population, 2010	805,029	5,773,552
Population, percent change, 2000 to 2010	6.7%	9.0%
Population, 2000	754,292	5,296,486
Persons under 5 years, percent, 2010	6.0%	6.3%
Persons under 18 years, percent, 2010	22.0%	23.4%
Persons 65 years and over, percent, 2010	14.6%	12.3%
Female persons, percent, 2010	52.7%	51.6%
White persons, percent, 2010 (a)	64.6%	58.2%
Black persons, percent, 2010 (a)	26.1%	29.4%
American Indian and Alaska Native persons, percent, 2010 (a)	0.3%	0.4%
Asian persons, percent, 2010 (a)	5.0%	5.5%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	0.0%	0.1%
Persons reporting two or more races, percent, 2010	2.4%	2.9%
Persons of Hispanic or Latino origin, percent, 2010 (b)	4.2%	8.2%
White persons not Hispanic, percent, 2010	62.7%	54.7%
Living in same house 1 year & over, 2005-2009	85.9%	85.5%
Foreign born persons, percent, 2005-2009	9.5%	12.3%
Language other than English spoken at home, pct age 5+, 2005-2009	11.4%	14.9%
High school graduates, percent of persons age 25+, 2005-2009	88.3%	87.5%
Bachelor's degree or higher, pct of persons age 25+, 2005-2009	34.3%	35.2%
Veterans, 2005-2009	65,045	461,622
Mean travel time to work (minutes), workers age 16+, 2005-2009	27.8	31.1
Housing units, 2010	335,622	2,378,814
Homeownership rate, 2005-2009	67.8%	69.6%
Housing units in multi-unit structures, percent, 2005-2009	27.9%	25.3%
Median value of owner-occupied housing units, 2005-2009	$259,400	$326,400
Households, 2005-2009	310,459	2,092,538
Persons per household, 2005-2009	2.47	2.63
Per capita money income in past 12 months (2009 dollars) 2005-2009	$33,158	$34,236
Median household income, 2009	$64,629	$69,193
Persons below poverty level, percent, 2009	8.3%	9.2%

Business QuickFacts	Baltimore County	Maryland
Private nonfarm establishments, 2009	20,040	135,633[1]
Private nonfarm employment, 2009	322,180	2,122,388[1]
Private nonfarm employment, percent change 2000-2009	2.5%	3.1%[1]
Nonemployer establishments, 2009	56,550	409,957
Total number of firms, 2007	76,111	528,112
Black-owned firms, percent, 2007	17.3%	19.3%
American Indian and Alaska Native owned firms, percent, 2007	0.3%	0.6%
Asian-owned firms, percent, 2007	6.1%	6.8%
Native Hawaiian and Other Pacific Islander owned firms, percent, 2007	0.1%	0.1%
Hispanic-owned firms, percent, 2007	2.2%	4.9%

Women-owned firms, percent, 2007	30.7%	32.6%
Manufacturers shipments, 2007 ($1000)	9,247,191	41,456,097
Merchant wholesaler sales, 2007 ($1000)	5,609,327	51,276,797
Retail sales, 2007 ($1000)	12,074,866	75,664,186
Retail sales per capita, 2007	$15,341	$13,429
Accommodation and food services sales, 2007 ($1000)	1,414,111	10,758,428
Building permits, 2010	1,230	11,931
Federal spending, 2009	8,766,789	96,070,970[1]
Geography QuickFacts	**Baltimore County**	**Maryland**
Land area in square miles, 2010	598.30	9,707.24
Persons per square mile, 2010	1,345.5	594.8
FIPS Code	005	24
Metropolitan or Micropolitan Statistical Area	Baltimore-Towson, MD Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report

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Appendix 1

FY 2011 Community Benefit Report Filing
Description of Financial Assistance Policy

GBMC has designed its Financial Assistance Policy with the intention of ensuring free and/or reduced care is available to patients. In administering its Financial Assistance Policy, GBMC utilizes an automated resource for scanning a patient's financial profile and/or an application process. Because GBMC's application process allows for a net asset test (i.e., a patient's necessary living expenses are taken into account), patients at or above 300% of the Federal Poverty Guidelines will typically qualify for free and/or reduced care.

In addition, 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

FY 2011 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

To every patient, every time, we will provide the care that we would want for our own loved ones. GBMC also dedicates itself to 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.