GBMC

FY 2012 Community Benefit Report Narrative

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS

Table I

Bed Designation	Inpatient Admissions	Primary Service Area Zip Codes	All Other Maryland Hospitals Sharing Primary Service Area	Percentage of Uninsured Patients, by County	Percentage of Patients who are Medicaid Recipients, by County
Acute Care - 281 Newborn Nursery - 60 NICU - 30 Skilled Nursing - 25	18,065 – Med/Surg Acute Care (excludes 4,232 births) 532 – Skilled Nursing Facility	21234 21093 21030 21117 21204 21286 21212 21236 21206 21208 21220 21136 21221 21222 21209 21239 21215 21207 21218 21237 21224 21244	St. Joseph Medical Center Sinai Hospital Franklin Square Hospital Good Samaritan Hospital Union Memorial Hospital Northwest Hospital Center	1.47% (for immediate service community)	5.26% (for immediate service community)

2. For purposes of reporting on your community benefit activities, please provide the following information:

a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

The primary service area is divided up into eight market segments, containing 52 zip codes, spanning areas of Baltimore County, Baltimore City, and Harford County. GBMC's primary service area accounted for ~74% of inpatient discharges in FY12. The map below highlights these segments.

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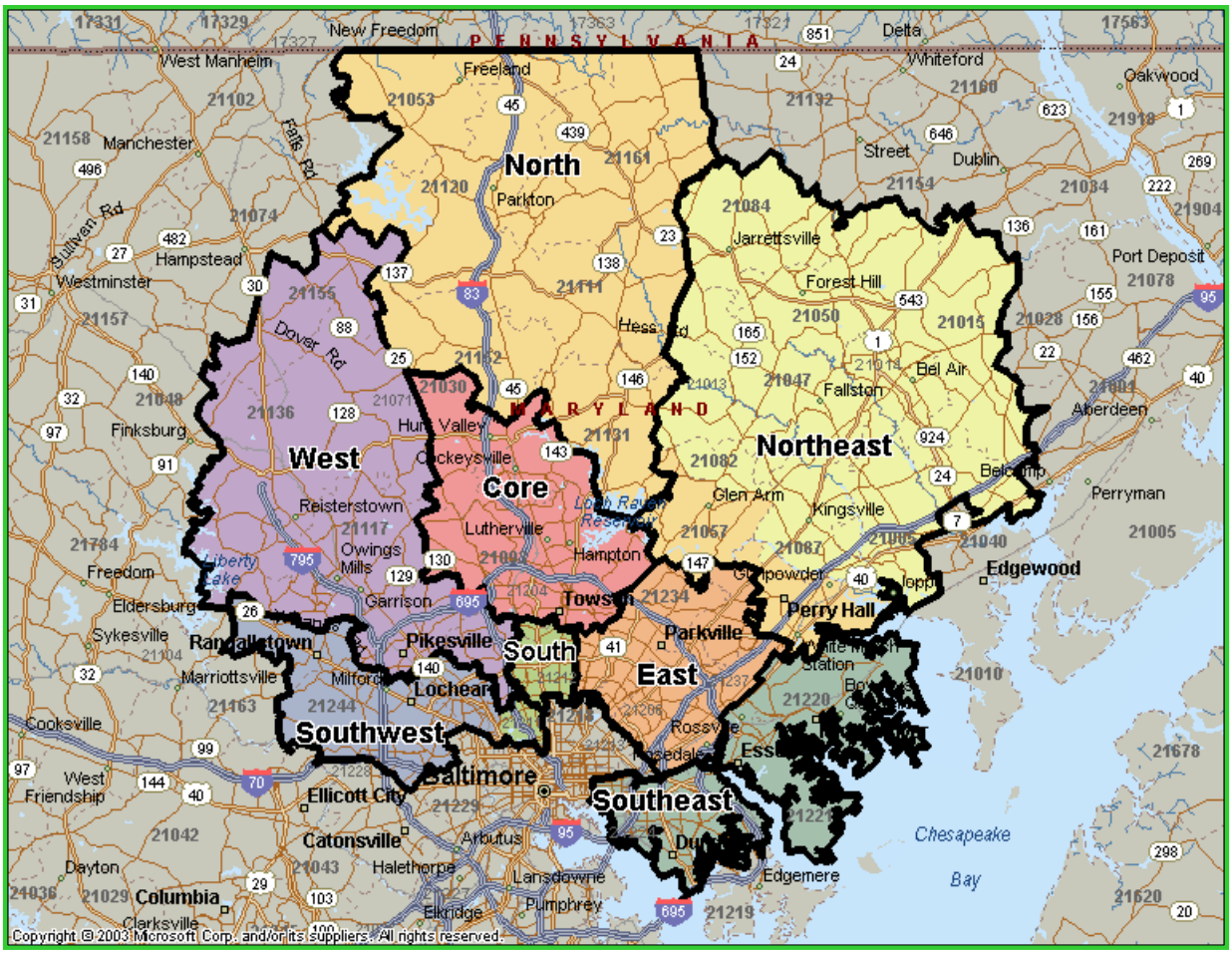

According to 2010 census data, there are approximately 1.1 million residents within GBMC's primary service area. The average annual income for this segment is $61,481, compared to the Maryland average of $68,688.

b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

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Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and average age)

Service Area Population by Gender and Age Cohort

Age Cohort	Male	Female	Total
0-14	107,093	102,975	210,068
15-17	24,907	23,854	48,761
18-24	52,294	54,446	106,740
25-34	76,110	83,593	159,703
35-54	151,158	169,157	320,315
55-64	62,483	72,671	135,154
65+	63,200	92,158	155,358
Total	537,245	598,854	########

Service Area Population by Race		
White	672,652	59.20%
Black	365,680	32.20%
Asian	46,461	4.10%
American Indian/Alaskan Native Alone	3,876	0.30%
Native Hawaiian/Pacific Islander Alone	487	0.00%
Some Other Race Alone	20,043	1.80%
Two or More Races	26,900	2.40%
Total	1,136,099	100.00%

Source: 2010 U.S. Census Data

Median Household Income within the CBSA

$61,481
Source: 2010 U.S. Census Data

Percentage of households with incomes below the federal poverty guidelines within the CBSA

~8.2%
Source: 2010 U.S. Census Data

Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml

Baltimore County	1.50%
Baltimore City	0.33%
Harford County	0.10%
TOTAL	1.94%

Source: St. Paul's Data

Percentage of Medicaid recipients by County within the CBSA.

Baltimore County	5.60%
Baltimore City	2.30%
Harford County	0.00%
TOTAL	7.90%

Source: St. Paul's Data

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).
See SHIP website: http://dhmh.maryland.gov/ship/SitePages/objective1.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx

Life Expectancy at Birth by Race and County, 2009-2011

	All Races	White	Black
Baltimore County	78.8	79.3	76.
Baltimore City	73.5	76.4	71.
Harford County	79.4	79.6	77.

Source: MD Vital Statistics

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).

Crude Death Rates* by Race and County, 2011

	All Races	White	Black	Asian or Pacific Islander	Hispanic
Baltimore County	936.0	1,146.2	583.7	221.9	101.0
Baltimore City	984.5	1,015.4	1,008.9	172.0	115.5
Harford County	751.4	821.1	464.2	187.1	198.9

* Per 100,000 population

Source: MD Vital Statistics

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx

SHIP Measure	Baltimore County	Baltimore City	Harford County	Maryland Baseline
Pop, 25+ Without H.S. Diploma**	10.7%	21.7%	8.5%	12.1%
Pop, 25+ With Bachelor's Degree or Above	34.9%	25.2%	30.6%	35.6%
% of Births where mother received 1st trimester prenatal care (VSA 2007-2009)	0.831	75.0%	84.8%	80.2%
% of people who report there was a time in the last 12 months they could not afford to see a doctor (BRFSS 2008-2010)	0.113	15.5%	10.4%	12.0%

Source: DHMH

Available detail on race, ethnicity, and language within CBSA.
See SHIP County profiles for demographic information of Maryland jurisdictions.

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 (GBMC) Community Needs Advisory Committee designed and developed a GAP Assessment that borrowed select statistical data on unmet healthcare needs of both the GBMC community and national community at large and aligned it with the services that GBMC could best serve. The GAP Assessment has acted as a guide for selecting certain community benefit activities for GBMC to pursue.

GBMC has engaged collaboratively with several local healthcare providers and will have a formal Community Needs Assessment completed in the Spring of 2013.

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

   GBMC has met with the Baltimore County Department of Health, Baltimore County Department of Aging and American Diabetes Association to understand the healthcare concerns of these agencies in GBMC's community.

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. X 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)
   - Dr. John Chessare, President & CEO
   - 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	X yes	_____no
Narrative	X yes	_____no

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IV. HOSPITAL COMMUNITY BENEFIT PROGRAM & INITIATIVE (Table III)

Initiative 1: Geriatric Nurse Practitioner

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	Evaluatin dates	Outcome	Continuation of Initiative
Access to Primary Care Services for Low Income Seniors	Geriatric Nurse Practitioner	GBMC employs 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. Primary Goal is to coordinate care and provide guidance for appropriate resources.	Multi-Year	Assoc of Catholic Towson Charities (Aigburth Vale, Gallagher House, Timothy House, Tabco Towers, Virginia Towers, Trinity House)	Monitored continuall y to evaluate the demand/v olume of services delivered	5,000 Seniors were Served. Because Seniors are better educated/informed, they are able to make better health-care decisions. By providing these Seniors with resources they experience better out-comes (i.e. less frequent hospital stays). **Predictor of Success-** Coordination of care and presence of a constant and trusted care provider (Geriatric NP) has proven invaluable in establishing meaningful patient-provider relationships, and ultimately aides in reducing waste – both in time and resources.	On-going

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Initiative 2: Providing Care to At-Risk Adolescents

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		160 patients were served yielding 1,500 annual visits. Because the primary Focus is education and treatment, the result is two-fold. By guiding at risk children and their parents to find specialized/routine care and treatment they have less absences from school and a better chance for success. **Predictor of Success-** The benefits of better Specialized care have reduced the frequency of Dr. and/or ED visits.	On-going

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Initiative 3: Prevention of Youth II Diabetes

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. **Predictor of Success-** 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

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Initiative 4: YOGA for Stroke Survivors

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		Program evaluated annually. Patients are evaluated at the beginning of the program and once they have completed the 6 week course.	120 patients were Served during FY 2012. This program has allowed patients to realize additional range-of-motion and other rehab benefits not ordinarily achieved through normal stroke rehab. **Predictor of Success-** Because the instructors are certified Physical Therapists and skilled in YOGA techniques, there is a greater likelihood that patients are able to achieve meaningful and sustained physical benefits.	On-going

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Initiative 5: SAFE

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
SAFE Program	The GBMC SAFE Program provides medical/forensic examinations for victims of sexual assault and rape in Baltimore County. GBMC is the only hospital in Balto. Co. to provide these services to victims 13 and above. The program provides compassionate care to these victims and forensic examinations provide invaluable evidence to law enforcement and the Balto. Co. State's Attorney's office for prosecution.	To provide a safe and compassionate environment for victims of sexual assault. Educate youth regarding sexual assault and how to prevent.	Multi-Year	Governor's Office of Crime Control and Prevention Verizon CareFirst Baltimore County State's Attorney's Office Department of Mental Health and Hygiene	Annual evaluation.	126 patients were served. 1,401 students of area High Schools attended lectures on Safe Dating. (A non measurable goal is to reach students and prevent the incidence of "date rape"). **Predictor of Success -** This program has paved the way for other programs around the nation and in the military	On-going

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.

2. If physician subsidies are listed in Category C (Mission Driven Services) of the Community Benefit Report, please indicate the category of the subsidy, and explain why the services would not otherwise be available to meet patient demand.

   Included in Category C of the Community Benefit report are physician subsidies to cover the following services for uninsured and Medicaid based patients.

   a. Guaranteed surgical services coverage for emergency room patients.
   b. Guaranteed availability of comprehensive obstetrical care to meet community need.

VI. APPENDICIES

Appendix 1

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:

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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 – Financial Assistance Policy (attached separately)

Appendix 3 – Patient Information Sheet (attached separately)

GBMC

PATIENT FINANCIAL SERVICES POLICY

FINANCIAL ASSISTANCE POLICY

APPROVAL:
Signature on File
Executive Vice-President and Chief Financial Officer

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. Self pay patients who are scheduled for non-emergency surgery must complete the Financial Assistance application prior to the scheduled procedure or they will be required to pay a deposit prior to the surgery

4. Patients who incur additional out-of-pocket by going out of the network specified by their insurance carrier, are not eligible for consideration

5. 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

   a. The IRS guidelines are followed in order to determine the number of family members that qualify to be counted as dependents

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)

   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.

   a. 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.

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

   c. Social Security Award Letter(s)

   d. Most recent unemployment insurance stub

e. Two most recent checking and savings account statements

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

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

h. 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

i. Medical Assistance denial or spend-down determination letter

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

k. 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)

   b. 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

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

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

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

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

g. $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

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

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

c. 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.

2. 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)

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

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

      i. Completed **Financial Evaluation**

      ii. Proof of household income

      iii. 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 but greater than $500

      i. Completed **Financial Evaluation**

      ii. Proof of household income

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

   c. Combined account balance(s) less than $500

      i. Completed **Financial Evaluation**

      ii. Proof of household income

iii. Application and proof of household income are tested to insure that liquid assets do not exceed the allowed amount

iv. Applications that meet the liquid asset test are screened through TransUnion to determine income eligibility (Refer to IV. Assumptive Financial Assistance)

v. Applications that do not meet the liquid asset test continue through the processes outlined below in section B

d. 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 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 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

   d. Applicants who own property in addition to their primary residence (residential or business), will not be considered for Financial 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

      i. “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)

3. 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.

III. ASSUMPTIVE FINANCIAL ASSISTANCE

Assumptive Financial Assistance is a program run in partnership with TransUnion credit reporting agency. Self pay accounts for Maryland residents 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 are eligible for Assumptive Financial Assistance screening at this time (exception balances after insurance under $500 that meet liquid asset test as spelled out under III. A. 4. c.)

2. Patients seen 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 considered under the Assumptive Financial Assistance program until the Value Options program has been billed

4. Uninsured patients who incur bills for elective surgical procedures will not be considered under the Assumptive Financial Assistance program (these patients may apply for consideration under our regular Financial Assistance program)

5. Self pay patients who are denied by Medical Assistance as over-scale in income are screened through the Assumptive Program

6. Self pay patients who are denied by Medical Assistance as over-scale in resources, must go through the regular Financial Assistance application process

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 initial 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)

a. Patients who have failed to respond to invoices or telephone attempts in order to confirm self pay status will not be processed under the Assumptive Program

b. Patients screened at time of service by the Advocacy Co-ordinator to confirm self pay status may be considered without need for additional patient contact

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 hospital bill under the Assumptive Financial Assistance write off code (CHARASSUMP) 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.

Responsible for Review: CFO

Date Reviewed: August 2012

GBMC
6701 North Charles Street
Baltimore, MD 21204

PERMISSIONS / ACKNOWLEDGEMENTS – Page 1 of 4

USE AND DISCLOSURE OF HEALTH INFORMATION – I authorize GBMC Healthcare and independent physicians or other practitioners providing services by or in the Health System to disclose any health information related to this hospitalization for my treatment as well as use of routine Health System operations and payment for services and associate care. I further authorize release of health information pertaining to this hospitalization to other health care providers for continuing care and treatment.

HEALTH INFORMATION EXCHANGES – We participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a state-wide health information exchange. As permitted by law, your health information will be shared among several health care providers or other health care entities in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. This means we may share information we obtain or create about you with outside entities (such as doctors' offices, labs, or pharmacies) or we may receive information they create or obtain about you (such as medical history or billing information) so each of us can provide better treatment and coordination of your healthcare services. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Even if you opt-out, a certain amount of your information will be retained by CRISP and your ordering or referring physicians, if participating in CRISP, may access diagnostic information about you, such as reports of imaging and lab results.

ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS – I hereby authorize payment directly to GBMC Healthcare of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the hospital and physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), "opt-out" plan, "out-of-network" preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

MEDICARE/MEDICAID PATIENT CERTIFICATION (for Medicare/Medicaid patients only) – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

I understand that I have been instructed to leave all valuables at home, give such valuables to a friend or family member, or if that is not possible, to deposit such valuables with the GBMC Security Office. I understand that I am responsible for safekeeping such items as eyeglasses, dentures, or hearing aides, or any of my property while it is in my possession or under my control. I release the hospital from any responsibility for loss of any item not deposited with the Security Office.

Has the patient received the Notice of Privacy Practices?
_____ Yes
_____ No

Reason no NOPP given:
_____Newborn
_____Patient Unable to Accept

PATIENT FINANCIAL POLICY

We are committed to providing you with quality and affordable health care. You are receiving this information because under Maryland law, GBMC must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance or your insurance does not cover your medically necessary hospital care and you have a low income.

Hospital Financial Assistance Policy:

- GBMC provides emergency and urgent care to all patients regardless of ability to pay.
- GBMC offers several programs to assist patients who are experiencing difficulty paying their hospital bills.
- GBMC complies with Maryland's legal requirement to provide financial assistance based on income level and family size.
- GBMC Patient Representatives are available to assist you with the application process **(see contact information on page 4)**, or you may access an application by going to http://www.gbmc.org/ (go to the Patient & Visitors Tab and then click Financial Support).

Patient Rights:

- Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.
- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance **(see contact information on page 4)**.
- You may be eligible for Maryland Medical Assistance a program funded jointly by the state and federal governments **(see contact information on page 4)**.

Patients' Obligations:

- For those patients with the ability to pay their hospital bill, it is the obligation of the patient to pay the hospital in a timely manner.
- GBMC makes every effort to see that patient accounts are properly billed. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under GBMC's financial assistance policy, or if you cannot afford to pay the bill in full you should contact the Patient Financial Services department promptly to discuss this matter **(see contact information on page 4)**.
- If you fail to meet your financial obligations for services received, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact Patient Financial Services to provide update/corrected information **(see contact information on page 4)**.

Insurance: We participate in most insurance plans, including Medicare. Please remember to always bring your insurance card with you when you come for a visit.

- **Co-payments and deductibles -** All co-payments and deductibles must be paid at the time of service. This arrangement may be part of your contractual agreement with your insurance company. Please assist us by being prepared to submit your co-payment for each visit.
- **Referrals/Authorizations/Pre-certifications** -You may be responsible for obtaining pre-certification, submitting a referral and/or authorization prior to being seen, if required by your insurance carrier (except Medicare). Please obtain your pre-certification, referral and/or authorization from your primary care physician and submit at the time of service.
- You may also be responsible for tracking your referrals (number of remaining visits and expiration date). Please obtain additional or new referrals as necessary.
- **Non-covered services** – Some, and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Please contact your insurance company with any questions you may have regarding coverage. If your insurance does not cover the service it does not necessarily mean that you do not need the service. Your physician will explain why he or she thinks that you can benefit from a service or procedure. If you elect to receive the non-covered service, you will be financially responsible.

- **Medicare patients** – If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice of Non-coverage (ABN). This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal Medicare's decision.
- **Claims submission** – We will submit your claim(s) and assist in any way we reasonably can to ensure claim payment. Your insurance company may require you to supply certain information directly. The balance of your claim is your responsibility regardless of your insurance company payment and GBMC is not party to that contract.
- **Coverage changes** – Please notify us before your next visit of any coverage changes so that we may assist you in maximizing your benefits.
- **Acceptable forms of payment** – We accept personal checks, money orders, Visa, MasterCard, Discover, American Express and we offer payment plans.

Physician Services:

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement. Depending upon your treatment plan, you may receive separate bills for all services rendered including but not limited to, GBMC, the physician treating you, Charles Emergency Physicians, Advanced Radiology, Physicians Anesthesia Associates, Radiation Oncology Healthcare, Greater Baltimore Pathology Associates, Pediatric Physicians, etc.

Contact Information:

- **GBMC Patient Representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m., at (443) 849-2450, option 1, or at 1-800-626-7766, option 1.**
- Our representatives can assist you with applying for Maryland Medical Assistance or you may also obtain information about or apply for Maryland Medical Assistance by contacting your local Department of Social Services by phone at 1-800-332-6347; TTY: 1-800-925-4434; or on the Internet at www.dhr.state.md.us.

I have read and understand in its entirety the information provided in this document and agree to follow its guidelines.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Relationship to Patient
(if signed by person other than the patient)

Appendix 4 – 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.