GBMC Financial Assistance Policy

POLICY STATEMENT

This policy applies to Greater Baltimore Medical Center, Inc., its division, GBMC Health Partners, and certain affiliates (collectively “GBMC”). GBMC is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications for financial assistance will be completed and evaluated retrospectively and will not delay a patient from receiving care.

GBMC patients, depending on their financial condition and subject to the criteria in this policy, may be eligible to receive medical assistance (Medicaid), full or partial financial assistance, or extended payment plans. To be consistent in the provision of financial assistance with all members of the community, GBMC applies definitive criteria, outlined herein, when making determinations of full or partial financial assistance.

This policy covers all hospital facility services and services provided by GBMC physician practices/practice groups delivering emergent or medically necessary care. This policy does not cover emergent or medically necessary care provided by non-employed providers with privileges at GBMC. **Exhibit A** lists all providers who may provide care to a patient at GBMC and indicates whether such provider is employed by GBMC. Non-employed providers bill separately for their services and should be directly contacted regarding any financial assistance options.

An individual who is eligible for full or partial assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance.

GBMC will give notice of its Financial Assistance Policy by providing access on its website and patient portal; providing notice of the policy in a newspaper with circulation in GBMC's service area on an annual basis; providing hard copies upon request and by mail free of charge; by providing notice and information about the policy as part of the pre-admission, registration, and discharge processes; providing notice and information on billing statements; and, by displaying information about the policy at the Billing Office and all hospital registration points, which includes the Emergency Department. English and Spanish versions of the Financial Assistance Policy and related documents will be made available in all locations and on the hospital website. Also, upon request, GBMC will translate the policy into all other primary languages of all significant patient populations in the community with limited English proficiency.

DEFINITIONS

A. Eligible Services: Medically necessary services, as defined below, may be eligible for financial assistance. Services that are not medically necessary are not eligible for financial assistance. Services for patients who incur additional out-of-pocket expenses, in compliance

with the federal No Surprises Act, by intentionally going out of their health insurance network, as specified by their insurance carrier, are not eligible for consideration.

B. Family Income: means the gross income of an individual and all of their Household Members, including, without limitation, compensation for services (wages, salaries, commissions, etc.), interest, dividends, royalties, capital gains, annuities, pension, retirement income, Social Security, public or government assistance, rents, alimony, child support, business income, income from estates or trusts, survivor benefits, income from life insurance or endowment contracts, and any other gross income or remuneration, from whatever source derived, all on a pre-tax basis.

C. Household Member: means an individual residing in the same household as the patient who:

   A. For a patient who is an adult, is a spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return; biological child, adopted child, or stepchild; and anyone for whom the patient claims a personal exemption in a federal or State tax return.

   B. For a patient who is a child, is a biological parent, adoptive parent, stepparent, or guardian; biological sibling, adopted sibling, or stepsibling; and anyone for whom the patent's parents or guardians claim a personal exemption in a federal or State tax return.

D. Liquid Assets: Cash, securities, promissory notes, stocks, bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property easily convertible to cash. A safe harbor of $150,000 in equity in a patient's primary residence shall not be considered an asset convertible to cash. Equity in other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the IRS has granted preferential tax treatment. Liquid Assets do not include the first $15,000 of monetary assets.

E. Medically Necessary Services: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of condition(s) that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction.

PROCEDURES FOR STANDARD WORK

TWO-STEP ELIGIBILITY PROCESS

Eligibility for full or partial financial assistance involves a two-step process. A patient or a patient's representative may seek and obtain a determination of probable eligibility before receiving a final determination of eligibility. The determination of probable eligibility is a prediction of eligibility for full or partial final assistance. To obtain full or partial financial assistance, a patient or patient representative must seek and obtain a final determination of eligibility.

A. **STEP ONE: DETERMINATION OF PROBABLE ELIGIBILITY**

1. Following a patient's or a patient representative's request for financial assistance, application for medical assistance, or both, GBMC will render and communicate to the patient or patient representative a determination of probable eligibility within two (2) business days.

2. To obtain a determination of probable eligibility of financial assistance, a patient or patient representative may:

   a. complete and submit a Request for Determination of Probable Eligibility (**Exhibit B**); or

   b. call and speak with a GBMC Financial Assistance representative at 443-849-2450.

3. Final determinations of eligibility will be based on all criteria and requirements set forth in this policy.

B. **STEP TWO: FINAL DETERMINATION OF ELIGIBILITY**

1. Application Requirements for Final Determination of Eligibility.

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

   b. Patients meeting eligibility criteria for medical assistance (Medicaid) must apply and be determined ineligible prior to GBMC's final financial assistance determination.

   c. Patients or patient representatives seeking full or partial financial assistance must submit a Maryland Uniform Financial Assistance Application (**Exhibit C**) and all of the applicable documentation listed on the financial assistance application letter (**Exhibit D**) or otherwise requested by GBMC that applies to the patient and other adult members of the household.

2. Procedures for Final Determination of Eligibility

   a. To qualify for full or partial financial assistance, a patient must supply all requested documentation and proof. Failure to supply requested information or documentation within 240 days (approximately 8 months) after receipt of the initial bill may be found ineligible for financial assistance.

   b. Each patient must agree to a credit bureau report as a condition of consideration for financial assistance.

   c. GBMC will communicate final determinations of eligibility for full or partial financial assistance in writing, directed to the address identified in the patient's Maryland Uniform Financial Assistance Application. If a patient is approved for financial assistance or a payment plan, he/she will receive a financial assistance award letter. If a patient is denied financial assistance, he/she will receive a denial letter.

d. Patients have the right to request an appeal of any denial by responding to the denial letter within fifteen (15) days of the date of the denial letter. Appeals will be reviewed by the Executive Director of Revenue Cycle Management, who will review the documentation submitted and make a determination based on this policy's criteria. The Executive Director of Revenue Cycle Management's decision is final, and patients who appeal an initial determination will receive a final appeal determination letter at least thirty days prior to any additional collection efforts.

e. Upon denial, patients have the right to request assistance from the Maryland Health Education and Advocacy Unit (HEAU) in filing and mediation of a reconsideration request. Requests for assistance should be directed to:

Health Education and Advocacy Unit
200 St. Paul Place
Baltimore, MD 21202
Email: heau@aog.state.md.us
Phone: (410) 528-1840 or 1 (877) 261-8807
FAX: (410) 576-6571
https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx

f. Financial assistance awards apply to all open accounts at the time of the financial assistance award and are valid for six months from the date of the financial assistance award for non-Medicare patients and for one year for Medicare patients.

C. **FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA**

1. For each patient, the percentage of the current Federal Poverty Level ("FPL") will be calculated, based on modified adjust gross income, as defined in the Federal Poverty Guidelines, and family size.
2. For patients with family income at or below 300% of the FPL, GBMC will provide 100% financial assistance for Eligible Services.
3. For patients with family income between 301%-500% of the FPL, GBMC will provide 50% financial assistance for Eligible Services.
4. For patient's 501% FPL, financial assistance will not be provided by GBMC, but a patient may request an income-based payment plan.
5. A patient may be found ineligible for financial assistance under this Section if the Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." GBMC will look at a patient's Liquid Assets, as defined above, and if such assets, combined with family income, exceeds 500% of the FPL, a patient will not be eligible for financial assistance.

D. **EXCLUSION CRITERIA**

The following patients are not eligible for financial assistance:

1. Uninsured and under-insured patients who do not meet the financial assistance criteria.

2. Patients who have insurance and chose self-pay for Eligible Services.
3. Patients seeking assistance for charges incurred for services that are not medically necessary.
4. Patients who are non-compliant with enrollment for publicly funded healthcare programs, charity care programs and other forms of financial assistance.
5. Patients who fail to provide accurate and complete financial information within 240 days (approximately 8 months) after receipt of the initial bill.

E. **PRESUMPTIVE FINANCIAL ASSISTANCE:**

1. In addition to the procedures described above, Presumptive Financial Assistance is an alternative method for obtaining financial assistance. It is a program run in partnership with an established credit reporting agency. Self-pay accounts for Maryland residents are referred to the agency, which utilizes a proprietary credit scoring system to determine the likelihood and ability to pay based on estimated income and family size. The results from the credit score are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection on certain accounts.
2. Presumptive Eligibility Based on Enrollment in Means-Tested Program: Patients enrolled in the following means-tested programs are deemed eligible for free care on a specific date of service. Patients are required to submit proof of enrollment within thirty (30) days of eligibility determination.
   a. Household Members - enrolled in the free and reduced-cost meal program;
   b. Enrolled in the federal Supplemental Nutrition Assistance Program (SNAP);
   c. Enrolled in State's Energy Assistance Program;
   d. Enrolled in Women, Infants, and Children (WIC);
   e. Enrolled in other social service program as determined by the Maryland Department of Health and the Health Services Cost Review Commission (HSCRC).

F. **COLLECTION EFFORTS:** The billing cycle will initiate fifteen 15 days after date of the denial letter. Three (3) billings statements are sent in 28-day intervals in attempt to collect the outstanding amounts. If there is no collection or payment arrangements made, the outstanding amounts are sent to a collection agency. If a patient files for bankruptcy during the financial assistance application process, award period, or during any collection efforts, the patient should provide written notification from the U.S. Bankruptcy Court to the GBMC Collection Manager. GBMC does not report delinquent accounts to any credit bureaus.