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Financial Assistance, Self Pay Collections, and Payment Plan Policy, FN 100

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This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:

Frederick Health is committed to providing quality medically necessary health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, sex, age, color, national origin or creed, marital status, sexual orientation, gender identity, or disability. The purpose of this document is to present a formal set of policies and procedures designed to assist Patient Financial Services personnel in the day-to-day application of this commitment. The procedures describe (1) how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications; (2) the manner in which Frederick Health will initiate collection actions and the write-off of accounts receivable as well as the subsequent placement of the receivables with outside agencies or attorneys for collection; and (3) how Frederick Health will offer payment plans in accordance with Maryland law. This policy documents a consistent practice for collecting amounts due from patients, regardless of insurance coverage, and the procedures necessary to record write-offs taken.

This policy is intended to comply with all applicable laws, including Section 501(r) of the Internal Revenue Code and Section 19-214.1 and Section 19-214.2 of the Health General Article of the Maryland Code and any implementing regulations. It has been adopted by the Board of Directors of Frederick Health Hospital, Inc. and Frederick Health, Inc. and shall be reviewed and approved by such Boards at least every two years unless more frequent approvals are required by law.

POLICY:

This policy applies to (1) patients seeking emergency or other medically necessary care at Frederick

Health Hospital ("FHH" or the "Hospital"), (2) patients seeking medically necessary professional medical services from Frederick Health Medical Group ("FHMG"), (3) patient accounts identified as self-pay or with a remaining patient responsibility after insurance and/or financial assistance for services provided by FHH or FHMG, and (4) any employee of FHH or FHMG who performs collection activity in the Patient Financial Services ("PFS") Department and any vendor that assists FHH or FHMG with its debt collection activities. For purposes of this policy only, FHH and FHMG are collectively referred to herein as "FHH/ FHMG."

The Financial Assistance procedures described in this Policy are designed to assist individuals who qualify for less than full coverage under available federal, state and local Medical Assistance programs but whose outstanding "self-pay" balances exceed their own ability to pay. The underlying principle is that a person, over a reasonable period of time, can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as Financial Assistance. In addition, the credit and collections procedures described in this Policy are designed to ensure that FHH/FHMG performs its credit and collection functions in a dignified and respectful manner and in compliance with all applicable laws.

PROCEDURE:

I. FINANCIAL ASSISTANCE

A. OVERVIEW

1. Financial Assistance can be offered before, during, or after services are rendered. After submission of an application, FHH/FHMG will send an acknowledgment letter to the patient within two (2) business days, and an eligibility determination will be made within fourteen (14) days of a completed application.
 - a. For purposes of this policy, "Financial Assistance" refers to healthcare services provided without charge or at a reduced charge to qualifying patients.
 - b. FHH/FHMG maintains a list of all providers who may care for patients while at FHH/FHMG available at <https://www.frederickhealth.org/find-a-provider/>. Only providers employed by FHH/ FHMG are covered under this policy and are indicated on the provider list. Non-FHH/ FHMG providers bill separately for their services, and not all participate in the FHH/FHMG Financial Assistance Program. If a provider is not covered under this policy, patients should contact the provider's office to determine if Financial Assistance is available.
 - c. Should a patient need assistance applying for Financial Assistance, help is available at our physical location at 400 West Seventh St. Frederick, MD 21701. Patients can also call 240-566-4214 with any inquiries regarding the Financial Assistance application process.
1. Notice of the Availability of Financial Assistance:
 - a. FHH/FHMG will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within FHH/FHMG locations.
 - b. Notices of the availability of Financial Assistance will be posted at appropriate admission areas, the Patient Financial Services department/billing office, and other

key patient access areas. Such notice will include who to contact for additional information.

- c. FHH/FHMG will ensure that applicable vendors post notice in a conspicuous place on their website or online payment portal informing patients of their right to apply for financial assistance, providing a link to the financial assistance application, and providing information on how to submit the application.
 - d. Written notice of the Financial Assistance Policy will be provided to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the bill as well as before the patient receives scheduled services, with the medical bill, and on request.
 - e. A statement on the availability of Financial Assistance will be included on patient billing statements.
 - f. A Plain Language Summary of the Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.
 - g. This Policy, a Plain Language Summary of the Financial Assistance Policy, and the Financial Assistance Application are available to patients upon request at FHH/FHMG, through mail (postal service), and on the FHH/FHMG website at <https://www.frederickhealth.org/about/billing-financial-assistance/>.
 - h. This Policy, the Plain Language Summary, and the Financial Assistance Application are available in Spanish.
 - i. On an annual basis, FHH/FHMG shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.
2. Availability of Financial Assistance: FHH/FHMG retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.
- a. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.
 - b. All patients presenting for emergency services will be treated regardless of their ability to pay.
 - i. For emergent services, applications for Financial Assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.
3. Limitation of Charges: Individuals receiving Hospital services who are eligible for reduced-cost care under this policy will not be charged more than the Hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).
- a. The Hospital's rate structure is governed by the HSCRC's rate setting authority. All patient care in the regulated hospital setting is charged according to the resources consumed in treating them regardless of the patient's ability to pay.

- b. Regulated hospital charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

A. PROGRAM ELIGIBILITY

1. FHH/FHMG strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. FHH/FHMG reserves the right to grant Financial Assistance without formal application being made by patients. These patients may include the homeless or those with returned mail with no forwarding address.
2. Patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care may be eligible for the FHH/FHMG Financial Assistance Program.
3. Healthcare services that are eligible for Financial Assistance are emergency medical care delivered by FHH and FHMG, other medically necessary care delivered by FHH, and most medically necessary services provided by FHMG as further provided herein.
 - a. For these purposes, emergency medical care means care provided by FHH for emergency medical conditions, which means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, emergency medical conditions means that: (i) there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) transfer may pose a threat to the health or safety of the woman or the unborn child.
 - b. For these purposes, medically necessary care, including care provided in accordance with the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), means care that is (i) directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; (ii) consistent with accepted standards of good medical practice; and (iii) not primarily for the convenience of the patient, the patient's family, or the provider.
4. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance program include the following:
 - a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);
 - i. Exceptions to this exclusion may be made, in FHH/FHMG's sole discretion, considering medical and programmatic implications.
 - b. Unpaid balances resulting from cosmetic or other non-medically necessary care;

- c. Patient convenience items; and
 - d. The categories of items and services provided by FHM, if any, listed on **Appendix B**.
5. Ineligibility: Patients may become ineligible for Financial Assistance, for a specific date of service, for the following reasons:
- a. After being notified by FHH/FHM, refusal to apply for or provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months). (If an individual submits an incomplete Financial Assistance Application within 240 days after the patient receives the first post-discharge billing statement, FHH/FHM shall give the individual a reasonable period to complete the application.)
 - b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to FHH/FHM due to insurance plan restrictions/limits.
 - c. Failure to pay co-payments as required by the Financial Assistance Program.
 - d. Failure to keep current on existing payment arrangements with FHH/FHM, as further detailed in this policy.
 - e. Failure to make appropriate arrangements on past payment obligations owed to FHH/FHM (including those patients who were referred to an outside collection agency for a previous debt).
 - f. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless FHH/FHM can readily determine that the patient would fail to meet the eligibility requirements.
6. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a collection agency if the balance remains unpaid in the agreed upon time periods.
7. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria set forth in Section I.D.2 below.
- a. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel, and recommendations shall be made to Senior Leadership for approval.
 - b. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.
8. Coverage amounts will be calculated using a sliding fee scale based on federal

poverty guidelines as further set forth in Section I.C below.

B. PATIENT FINANCIAL ASSISTANCE GUIDELINES

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale as described in this section and in **Appendix A**.
2. As indicated in **Appendix A**, the income levels used for purposes of calculating eligibility refer to a patient's household/family income.
 - a. FHH/FHMG shall define income for this purpose in compliance with applicable law, including applicable HSCRC regulations.
 - b. The family unit or household includes the following:
 - i. If the patient is an adult, the family unit/household includes, at a minimum, the patient and the following individuals who live in the same dwelling: (i) a spouse (regardless of whether the patient and spouse expect to file a joint federal or state tax return); (ii) biological, adopted, or step-children; and (iii) all individuals on the same federal or state tax return, including anyone for whom the patient claims a personal exemption in a federal or state tax return; and
 - ii. If the patient is a child, the family unit/household includes, at a minimum, the patient and the following individuals who live in the same dwelling: (i) biological, adopted, or step-parents or guardians; (ii) biological, adopted, or step-siblings; and (iii) all individuals on the same federal or state tax return, including anyone for whom the patient's parents or guardians claim a personal exemption in a federal or state tax return.
3. A patient's eligibility for Financial Assistance shall be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial medical bill is provided as long as the patient informs FHH/FHMG of the change in financial circumstance on or before the conclusion of such period.
4. US Federal Poverty guidelines are updated annually by the Department of Health and Human Services and are available at <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/>.

C. PRESUMPTIVE FINANCIAL ASSISTANCE

1. Patients may be eligible for Financial Assistance on a presumptive basis. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance application and/or supporting documentation on file. Often there is adequate information provided by the patient or other sources that is sufficient for determining Financial Assistance eligibility.
 - a. In the event there is no evidence to support a patient's eligibility for Financial Assistance, FHH/FHMG reserves the right to use outside agencies or propensity to pay modeling in determining Financial Assistance eligibility.

- b. Patients who are determined to satisfy presumptive eligibility criteria will receive free care on that specific date of service only.
2. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
 - a. Active Medical Assistance pharmacy coverage;
 - b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
 - c. Homelessness;
 - d. Maryland Public Health System Emergency Petition patients;
 - e. Being a beneficiary/recipient of the following means-tested social service programs: Women, Infants and Children Programs ("WIC"); Food Stamp/ Supplemental Nutritional Assistance Program; households with a child who is enrolled in the free and reduced-cost-meal program and is eligible for the program based on the household's income; low-income-household energy assistance program; Primary Adult Care Program ("PAC"), until such time as inpatient benefits are added to the PAC benefit package; or other means-tested social services programs deemed eligible for hospital free medically necessary care policies by the Maryland Department of Health and the HSCRC, consistent with HSCRC regulations;
 - f. Eligibility for other state or local assistance programs;
 - g. Deceased with no known estate; and
 - h. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.
3. Patients deemed to be presumptively eligible for Financial Assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.

D. MEDICAL HARDSHIP PROGRAM

1. A patient who does not qualify for Financial Assistance described elsewhere in this policy may qualify for Financial Assistance under FHH/FHMG's Medical Hardship Program if they have incurred collective family medical debt at FHH/FHMG, exceeding 25% of the combined household income, during a 12-month period, regardless of income.
 - i. Medical debt for this purpose is defined as out-of-pocket expenses for medically necessary care received at FHH/FHMG, including co-payments, co-insurance, and deductibles, that are billed to a patient or co-signer for the patient excluding amounts contractually paid by another payer.
2. FHH/FHMG applies the medical debt criteria set forth above to a patient's balance after any insurance payments have been received.
3. If determined eligible, patients and their immediate family members living in the

same household qualify for a 20% reduction in the cost of medically necessary care received from FHH/FHMG for a 12-month period effective on the date the medically necessary care was initially received. To avoid unnecessary duplication, such patients and their immediate family members living in the same household shall inform the hospital of the patient's or family member's eligibility.

4. Patients are required to notify FHH/FHMG of their potential eligibility for the Medical Hardship Program.
5. For purposes of clarification and avoidance of doubt, FHH/FHMG's standard Financial Assistance program provides for a greater than 20% reduction in the cost of medically necessary care for patients with a family income at or below 500% of the federal poverty level as indicated on **Appendix A** of this Policy. As a result, patients with a family income at or below 500% of the federal poverty level are eligible to receive Financial Assistance without regard to their family's medical debt. Patients who are therefore eligible for the Medical Hardship Program are those with a family income above 500% of the federal poverty level.

E. ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES: FHH/FHMG reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of criteria required by law or established by this policy.

1. The eligibility, duration, and discount shall be patient-situation specific.
2. Patient balance after insurance accounts may be eligible for consideration.
3. Cases falling into this category require management review and approval.
4. On a case-by-case basis and with the input of FHH/FHMG's legal counsel, management can develop a special financial assistance program for particular categories of patients under this section. The financial assistance provided under any such special program shall be at least consistent with but may exceed the assistance that would otherwise apply under this Policy.

F. ASSET CONSIDERATION

1. Household monetary assets are generally not considered as part of a patient's Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When household monetary assets are reviewed, individual patient financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.
2. When determining eligibility for Financial Assistance under this policy, FHH/FHMG may consider only household monetary assets in excess of \$100,000 that can readily be converted into a fixed or precisely determinable amount of money, including cash and cash equivalents (e.g., cash on hand, bank deposits, investment accounts, accounts receivable, and notes receivable); provided, however, that retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment (including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred compensation plans), shall be excluded. (Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.)

G. APPEALS/COMPLAINTS

1. Patients whose Financial Assistance applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: Frederick Health, 400 West Seventh Street Frederick, MD 21701 Attn: Financial Counseling Team.
2. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
3. Appeals are documented and reviewed by the next level of management for additional reconsideration.
4. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
5. Appeals can be escalated up to the Chief Financial Officer who will render the final decision.
6. Patients who have formally submitted an appeal will receive a letter of the final determination.
7. Patients have thirty (30) days after denial to submit their appeal.
8. The Health Education and Advocacy Unit ("HEAU") is available to assist patients and their authorized representatives in filing and mediating reconsideration requests/ appeals. The HEAU can be contacted using the following information:
Office of the Attorney General Consumer Protection Division Health Education and Advocacy Unit 200 Saint Paul Place
Baltimore, Maryland 21202
Phone number: 410-528-1840 or 1-877-261-8807 Email address: heau@oag.state.md.us
Fax number: 410-576-6571
Website: <https://oag.maryland.gov/our-office/Pages/heau.aspx>
9. Patients may file a complaint against a hospital for an alleged violation of its Financial Assistance Policy by sending the complaint to the Maryland Health Services Cost Review Commission (HSCRC) at hscrc.patient-complaints@maryland.gov. The HSCRC can also be contacted at 410-764-2605 or 1-888-287-3229 and can be found online at <https://hscrc.maryland.gov/Pages/default.aspx>. Complaints may also be filed jointly with the HEAU using the information provided above.

H. PATIENT REFUND/CORRECTIVE ACTION

1. If a patient is found to be eligible for free or reduced-cost care under FHH/FHMG's Financial Assistance Program within 240 days after the initial bill was provided to the patient, the patient shall be refunded payments in excess of \$25. FHH/FHMG shall make such refunds within 30 days following FHH/FHMG's determination of the patient's eligibility. Notwithstanding anything to the contrary provided above, if a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital services, FHH/FHMG shall provide for a refund that complies with the terms of the patient's plan.

2. If a patient is found to be eligible for Financial Assistance after FHH/FHMG has initiated extraordinary collection actions (ECA) as described in this Policy, FHH/FHMG will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken (*i.e.*, to vacate the judgment or strike the adverse information).
3. For purposes of clarification and avoidance of doubt, the patient's eligibility for Financial Assistance for purposes of this Section I.I shall be calculated consistent with Section I.C.

I. OPERATIONS

1. FHH/FHMG will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
 - a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
 - i. To facilitate this process, each applicant must provide information about family size and income (as defined by Medicaid regulations).
 - b. FHH/FHMG will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
 - i. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit the following for validation purposes:
 - a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
 - b. Proof of disability income (if applicable);
 - c. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
 - d. Proof of social security income (if applicable);
 - e. A Medical Assistance Notice of Determination (if applicable);
 - f. Reasonable proof of other declared expenses; and

Assistance shall be effective as of the date treatment is received and the following twelve (12) calendar months.

- a. Presumptive Financial Assistance cases will apply to the date of service only.
 - b. Financial Assistance for patients who reside outside of the United States will apply to the date(s) of service only, unless otherwise determined by management in its sole discretion.
 - c. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive Financial Assistance.
2. The following may result in the reconsideration of Financial Assistance approval:
- a. Post approval discovery of an ability to pay; and
 - b. Changes to the patient's income, assets, expenses or family status, which are expected to be communicated to FHH/FHMG.
3. FHH/FHMG will track patients' qualification for Financial Assistance including under the Medical Hardship Program. However, it is ultimately the responsibility of the patient to accurately inform FHH/FHMG of their eligibility status (and any updates to such eligibility) at the time of registration, upon receiving a statement, or at any other time.
4. FHH/FHMG will not use a patient's citizenship or immigration status as an eligibility requirement for Financial Assistance or withhold Financial Assistance or deny a patient's application for Financial Assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or disability.

I. CREDIT & COLLECTIONS

A. OVERVIEW

1. FHH/FHMG expects patients to pay for services at the time service is provided or within thirty (30) days of the first billing statement for services not covered by insurance or Financial Assistance, unless the patient and FHH/FHMG have entered into an approved payment plan in accordance with this policy.
2. FHH/FHMG must take effective action to maintain timely accounts receivable turnover and ensure that the value of accounts receivable is accurately stated. To do this, patient accounts will be aged and written off as bad debts or charity and may be outsourced to collection agencies for further follow-up.
3. Emergency services will be provided to all patients regardless of ability to pay. Scheduled services will be provided after appropriate financial arrangements are confirmed by FHH/FHMG. In compliance with this Policy and applicable law, FHH/FHMG may require deposits prior to scheduling services, and the failure to pay required deposits may result in the rescheduling of non-emergent services.
4. FHH/FHMG may use external collection agencies for extended business office, legal and/or collection activity to assist with collecting on patient accounts. FHH/FHMG will provide active oversight of any collection agency that collects debts on their behalf, and such agencies shall be required to abide by this policy.

A. CASH COLLECTIONS

1. Payment for identified co-payments and deductibles will be requested prior to or at the time of service as further described in this Policy and in compliance with applicable law. In the case of emergency services, no payment shall be requested until after a patient has received a medical screening exam and any necessary stabilizing treatment.
2. FHH/FHMG accepts cash, checks and credit cards to settle outstanding accounts.
3. Medically necessary care will not be deferred or denied due to an outstanding balance for previously provided care.
4. There may be scenarios that occur during the collection process outlined in this policy that may result in placing a hold on collection efforts (called an "administrative hold") until additional information is provided. All accounts on administrative hold will be compiled into a report by threshold levels for review by management on a monthly basis, with certain levels being reviewed on a weekly basis.
5. An account balance is delinquent when a payment in full has not been received within forty-five (45) days after receipt of first bill, unless the patient has entered into a payment plan.

A. PAYMENT PLANS

1. FHH/FHMG may make payment arrangements for patients to resolve open balances within a reasonable timeframe.
2. *Availability.* FHH/FHMG shall make income-based payment plans available to help all patients who are United States residents, regardless of income, pay for medically necessary hospital care at FHH, as well as most medically necessary services provided by FHMG (to be determined by management in its discretion), after care has been provided.
 - a. Such income-based payment plans shall be available to all patients who are United States residents (including those temporarily residing in the United States due to work or school) irrespective of their insurance, citizenship, or immigration status or eligibility for Financial Assistance in accordance with this Policy.
 - b. FHH/FHMG is not obligated to make income-based payment plans available to patients who reside outside of the United States. To the extent FHH/FHMG does make a payment plan available to a patient who resides outside of the United States, FHH/FHMG is not required to comply with the requirements of Section II.C of this Policy. For purposes of example only, this means that FHH/FHMG may require a patient who resides outside of the United States to make monthly payments on a payment plan that exceeds 5% of the patient's adjusted gross monthly household income.
 - c. The provisions of Section II.C of this Policy apply to income-based payment plans. FHH/FHMG does not intend to make non-income-based payment plans available to patients; however, any non-income-based payment plan offered by FHH/FHMG shall comply with all applicable laws and regulations.
3. *Prepayment Plans.* The criteria set forth in Section II.C of this Policy do not apply to arrangements to make payments prior to the provision of a FHH/FHMG service (a "prepayment plan"). FHH/FHMG may offer patients a prepayment plan as long as it follows all applicable laws in doing so, including with respect to providing written notice to patients of the availability

of financial assistance and income-based payment plans and processing any request for financial assistance. Any such prepayment plan arrangement shall terminate once the applicable service is rendered.

4. *Notice.*
 - a. FHH/FHMG shall provide information about the availability of income-based payment plans in the following manner.
 - i. FHH/FHMG will post notice of the availability of income-based payment plans and who to contact for additional information in conspicuous places within FHH/FHMG locations, including the billing office.
 - ii. FHH/FHMG will ensure that applicable vendors post notice in a conspicuous place on their website or online payment portal regarding the availability of income-based payment plans and whom to contact for additional information.
 - iii. FHH/FHMG will provide written notice of the availability of income-based payment plans in information provided to patients or the patient's family, authorized representative, or legal guardian before the patient receives scheduled services, before discharge, with the medical bill, on request, and in each written communication to the patient regarding collection of medical debt.
 - iv. FHH/FHMG will provide written notice of the availability of an income-based payment plan before a patient enters into a prepayment plan as described above.
 - v. FHH/FHMG will provide information regarding income-based payment plans on bills and online payment portals in accordance with law.
 - a. FHH/FHMG will provide written notice of the terms of an income-based payment plan to a patient before the patient agrees to enter into the income-based payment plan in accordance with applicable law.
 - b. FHH/FHMG will promptly provide a copy of the written income-based payment plan with required terms to the patient following execution by all parties at least 20 days before the due date of the patient's first payment under the plan.
1. *Financial Assistance; Income Documentation.* Before entering into a payment plan with a patient, FHH/FHMG shall evaluate if the patient is eligible for Financial Assistance (including free care, reduced-cost care, and reduced-cost care due to medical hardship) in accordance with this Policy.
 - a. FHH/FHMG shall apply any applicable Financial Assistance reduction prior to entering into a payment plan.
 - b. FHH/FHMG shall use any information collected for determining Financial Assistance to establish the patient's payment threshold under the payment plan.
- i. If the patient attests that the patient does not qualify for Financial Assistance, FHH/FHMG may accept the patient's attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation to confirm the patient's ineligibility for Financial Assistance and to establish the patient's payment threshold under the payment plan.
1. *Criteria, including Monthly Payment Amounts, Interest, and Fees.* When entering into payment

plan arrangements with patients, FHH/FHMG:

- a. May not require a patient to make total payments in a month under all income-based payment plans provided to the patient by FHH/FHMG that exceeds 5% of the patient's monthly household income, calculated and determined in accordance with this Policy, applicable law, and HSCRC guidance, including, without limitation, in terms of what constitutes monthly household income and how to take into consideration household size when determining the monthly payment amount.
 - b. May consider whether to reduce the monthly payment amount due upon consideration of household expense information provided by a patient.
 - c. Shall prohibit interest payments or fees for patients who qualify for Financial Assistance under this Policy.
 - d. May consider whether to impose interest payments for patients who are not eligible for Financial Assistance under this Policy. Any such interest must comply with applicable HSCRC guidance and may not begin before 240 days after the initial bill is provided.
 - e. Shall prohibit penalties or fees for prepayment or early payment or late payments.
 - f. Shall apply partial payments in a manner most favorable to the patient.
1. *Duration.* FHH/FHMG shall determine the duration of the patient's payment plan, in months, by the total amount owed and interest (if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5% of the patient's income as described in this Policy.
 2. *No solicitation; prepayment rules.* FHH/FHMG shall not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in an income-based payment plan. Any prepayment made by a patient on a voluntary basis is not subject to the monthly income payment limitation stated in this Policy.
 3. *Modifications.*
 - a. FHH/FHMG shall only modify a payment plan in a manner that complies with this Policy and applicable law.
 - b. Requests for modification shall be made by contacting the FHH/FHMG Business Office at 240-566-3055. FHH/FHMG shall respond to all such requests in a timely manner and may not refer the outstanding balance owed to a collection agency or for legal action until 30 days after providing a written response to the patient's request.
 - c. If a patient notifies FHH/FHMG that the patient's income has changed, FHH/FHMG shall offer to modify the patient's payment plan.
 - d. If a patient requests a modification, FHH/FHMG must consider patient's eligibility for Financial Assistance and apply any Financial Assistance reduction in its modification. FHH/FHMG also must consider information provided by the patient about changes in household expenses.
 - e. FHH/FHMG may not increase the interest rate when modifying any income-based payment plan.
 - f. FHH/FHMG may not modify the payment plan in a way that requires a patient to make a monthly payment that exceeds the 5% monthly income limitation described above.

- g. The patient and FHH/FHMG must mutually agree to any modified payment plan, unless otherwise permitted by law.
 - h. FHH/FHMG shall provide the patient with a written notice of all payment plan terms consistent with this Policy upon modifying a payment plan.
1. *Hospital-Initiated Changes.* FHH/FHMG may, in the terms of a written payment plan that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as long as such recalculations are in compliance with this Policy, written notice of such calculations was provided to the patient before they entered into the plan, and such recalculations do not occur more than once every 3 years. If a patient does not provide income information upon request, FHH/FHMG shall not change the monthly payment amounts as long as the patient is in good standing on the payments under the current payment plan.
 2. *Treatment of Missed Payments.*
 - a. **First Missed Payment.** Patients shall be deemed compliant with a payment plan if the patient makes at least eleven (11) scheduled monthly payments within a twelve (12) month period. FHH/FHMG shall comply with applicable law with respect to the treatment of missed payments, including as follows:
 - i. Within thirty (30) days after such first missed payment, FHH/FHMG shall notify the patient of the missed payment and inform the patient that the patient may be in default if they do not pay the amount of the missed payment within twelve (12) months or if they miss additional payments within the twelve (12) month period.
 - ii. FHH/FHMG will comply with HSCRC guidance with respect to the options for patients to pay the missed payment and how catch-up payments shall be designated.
 - iii. FHH/FHMG may consider a patient to be in default on the plan if the missed payment is not repaid in full by the end of the twelve (12) month period that begins on the date of the first missed payment.
 - iv. Any catch-up payments paid by a patient pursuant to this section are not subject to the monthly income limitation stated in this Policy.
 - a. **Additional Missed Payments.** FHH/FHMG may, in its sole discretion, decide to forbear the amount of any additional missed payments that occur in a twelve (12) month period. If FHH/FHMG decides to forbear the amount of any such additional missed payments, then FHH/FHMG:
 - i. shall allow the patient to continue to participate in the payment plan,
 - ii. may not refer the outstanding balance owed to a collection agency or for legal action,
 - iii. shall recapitalize the amount of any such missed payments as additional payments at the end of the payment plan, thereby extending the length of such plan, and
 - iv. provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the plan.
 1. *Default.* Payment arrangements that remain current as set forth herein will not be forwarded to bad debt collections, and FHH/FHMG may not consider such patients in arrears on their debt

when making decisions about the scheduling of health care services. If a patient defaults on a payment plan and the parties are unable to agree to a modification, then FHH/FHMG shall follow the remaining portions of Section II of this Policy, including with respect to forwarding the account to bad debt collections in compliance with this Policy and applicable law.

2. *Books and Records.* FHH/FHMG shall retain books and records on payment plans for at least three (3) years after each such payment plan is closed.

A. **CREDIT BALANCE ACCOUNTS**

1. FHH/FHMG will not refund insurance over-payments to the guarantor (patient or guardian) until all accounts for which the guarantor is responsible are paid in full. "Paid in full" means that the total account balance(s) owed are zero and not waiting for an insurance payment.
2. Approved refunds will be issued on a reasonable and regular basis.

A. **ACCOUNTS RECEIVABLE**

1. Patient statements, letters, or data mailers will be sent to patients on a 30-day cycle. Patients and/or guarantors will receive four (4) or more statements in approximately 120 days of the date on which the patient's financial responsibility has been determined. This time period can be extended in certain circumstances, including, for example, if a patient applies for Financial Assistance.
2. Depending on the patient's balance, age of account, and other variables, phone calls may be placed with patients/guarantors to collect on outstanding balances.
3. If the patient/guarantor has not made a payment within 120 days of the first billing date, or if the terms of an approved payment plan are not being met, the account shall be eligible for placement with a collection agency.
4. If a statement is returned to FHH/FHMG from the U.S. Post Office with an incorrect address, the account will be researched to find a correct address. If a correct address is not found, the account shall be placed with a collection agency prior to 120 days of the first billing date to assist in further collection efforts.
5. FHH/FHMG contact information and a notice of availability of Financial Assistance and payment plans shall be included on all statements or other communications regarding collection that are sent to the guarantor/patient.

A. **WRITE-OFF REVIEW**

1. If a patient account reaches a pre-determined aging with no account payment activity, or where the terms of an approved payment plan are not being met, the account will be assessed for possible small balance, bad debt or charity write off as follows:
 - a. **Small Balance Write-Offs:** An automated process will be used to identify accounts with a debit balance. The accounts are processed with adjustment transactions and do not pass to bad debt, but rather to established "small balance write-off" codes for balances outlined in the Responsibility section of this policy.
 - b. **Bad Debt Write-Offs:** A periodic report will be generated to "pre-list" self-pay and self-pay after insurance accounts that may meet bad debt criteria outlined in the Responsibility section. Those accounts will be subject to review by management,

including based upon dollar balance, prior to submitting into bad debt status.

- i. Only specific employees in the PFS Department will be given access to the bad debt functions in the patient accounting system.
- ii. Unless an administrative hold is placed on an account that has qualified for the bad debt pre-list, all accounts will be moved into a bad debt status during the overnight batch processing within the patient accounting system.
- iii. Consistent with Maryland law regarding balance billing, accounts with a third-party insurance balance that have no insurance payment from the insurer for sixty (60) days may have that balance deemed to be self-pay. At that time, the patient may begin to receive statements in the same manner as a self-pay patient.
- iv. Wherever appropriate, write-offs shall be identified as charity care in accordance with this Policy. Any write-offs so identified will not be referred to any outside collection agencies.
- v. Patients may request, or may be requested by FHH/FHMG, to apply for Medical Assistance (*i.e.*, Medicaid) prior to being awarded Financial Assistance. This request may be made prior to service, at the time of service, or during the billing and collection cycle. The account in question will not be forwarded to a collection agency during the Medical Assistance application process.

A. DEBT COLLECTIONS

1. Where appropriate, FHH/FHMG may use a bad debt collection agency to continue to try to collect on greater than 120 day after first bill aged accounts (*i.e.*, FHH/FHMG will not refer accounts to a collection agency prior to 120 days after the first post-discharge billing statement). Patients with balances that have been referred to a collection agency must resolve unpaid balances, request a payment plan in accordance with this Policy, dispute amounts owed, or request Financial Assistance. Collection agencies may assess finance charges and fees on the unpaid principal account balance to the extent permitted by applicable law and this Policy.
 - a. Notwithstanding anything to the contrary provided in this Policy, for a patient who is eligible for Financial Assistance, FHH/FHMG (and any collection agencies acting on their behalf) cannot:
 - (i) charge interest on the debt owed on a bill for the patient before a court judgment is obtained; or
 - (b) collect fees or any other amount that exceeds the approved charge for the hospital service as established by the HSCRC.
1. For self-pay accounts that have not been assessed for Financial Assistance eligibility, FHH/FHMG shall provide written notice to the patient or responsible party at least thirty (30) days prior to referring an account to a bad debt collection agency. Such written notice shall:
 - a. Inform the patient of the availability of financial assistance and payment plans;
 - b. Identify the collection actions that FHH/FHMG plans to initiate to obtain payment;
 - c. State a deadline after which such collection actions may be initiated that is no earlier than 30

- days after the date that the written notice is provided; and
- d. Include a plain language summary of FHH/FHMG's Financial Assistance Policy.
 1. FHH/FHMG shall make a reasonable effort to orally notify the individual about FHH/FHMG's Financial Assistance Policy and the process for applying.
 2. Balances that remain open due to insurance denials will not be placed with a collection agency. However, a collection agency may perform payer collections on insurance denials acting as an extension of the business office.
 3. Circumstances, such as pending eligibility for Financial Assistance or insurance coverage with Medicaid, may delay an account from being referred to a collection agency.
 4. Patients may file a grievance/complaint with FHH/FHMG regarding the treatment or undesirable activities performed by FHH/FHMG or their contracted collection agencies regarding the handling of a patient's bill by contacting the Services Excellence Department at 240-566-3564 or patientexperience@frederick.health. Contracted collection agencies shall be instructed to forward to FHH/FHMG any patient grievance/complaint filed with such collection agency.
 5. FHH/FHMG shall not engage in the following extraordinary collection actions ("ECAs") against an individual to obtain payment for care: (i) selling an individual's debt to another party except to a governmental unit or an entity that is under contract with that unit or to a nonprofit, 501(c)(3) tax-exempt organization for the sole purpose of canceling the debt in compliance with applicable Maryland law, including, without limitation, MD Code, Health-Gen. § 19-214.2; (ii) deferring or denying or requiring a payment before providing medically necessary care because of nonpayment of one or more bills for previously provided care covered under the Financial Assistance Policy; (iii) requesting a lien against or forcing the sale or foreclosure of an individual's primary residence to collect a debt owed on a medical bill; (iv) garnishing an individual's wages; (v) attaching or seizing an individual's bank account or any other personal property; (vi) causing an individual's arrest; (vii) causing an individual to be subject to a writ of body attachment; (viii) reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus; and (ix) filing a civil action to collect a debt against an individual whose outstanding debt is at or below \$500.
 6. Although FHH/FHMG does not typically take such actions in the normal course of collection, it reserves the right to pursue collections through the following ECAs (the "Permitted ECAs") at the direction of senior management after verification of the individual's ability to pay and a determination of the individual's eligibility for Financial Assistance: (i) commencing a civil action to collect a debt against an individual whose outstanding debt is above \$500; and (ii) requesting a lien against or forcing the sale or foreclosure of an individual's real property other than a primary residence to collect a debt owed on a medical bill.
 7. FHH/FHMG shall neither take the Permitted ECAs nor give written notice to a patient of the intent to file an action as set forth below in Section II.G(11) until 240 days after the initial bill was provided.
 8. FHH/FHMG cannot make a claim against the estate of a deceased patient to collect a debt owed on a medical bill if the deceased patient was known by FHH/FHMG to be eligible for free care under the Financial Assistance Policy or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed. FHH/FHMG may offer the family of the deceased patient the ability to apply for Financial Assistance.

9. At least 45 days before filing an action against a patient to collect on the debt owed on a medical bill, but not within 240 days after the initial bill is provided, FHH/FHMG must send written notice of the intent to file an action to the patient in a form and manner that complies with Section 19-214.2 of the Health General Article of the Maryland Code and any implementing regulations.
10. If FHH/FHMG files an action to collect a debt owed on a medical bill by a patient, the complaint shall comply with all applicable requirements of Section 19-214.2 of the Health General Article of the Maryland Code, including, without limitation, with respect to the documents and information that must be included with or in such complaint.
11. FHH/FHMG shall report the fulfillment of an individual's payment obligation within sixty (60) days after the obligation is fulfilled to any consumer reporting agency to which it had reported adverse information about the individual, including if the debt was sold to a governmental unit or an entity under contract with that unit or to a nonprofit, 501(c)(3) tax-exempt organization for the sole purpose of canceling the debt in compliance with applicable Maryland law, including, without limitation, MD Code, Health-Gen. § 19-214.2. If FHH/FHMG reported adverse information about a patient to a consumer reporting agency, it shall instruct the consumer reporting agency to delete the adverse information about the patient by November 1, 2025.
12. FHH/FHMG shall not delegate collection activity to a debt collector or take the Permitted ECAs if FHH/FHMG (i) was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days; (ii) is processing a requested reconsideration of the denial of free or reduced cost care under the Financial Assistance Policy that was appropriately completed by the patient or has completed the reconsideration within the immediately preceding 60 days; or (iii) has sold the debt to a governmental unit or an entity under contract with that unit or to a nonprofit, 501(c)(3) tax-exempt organization for the sole purpose of canceling the debt in compliance with applicable Maryland law, including, without limitation, MD Code, Health-Gen. § 19-214.2.
13. A spouse or another individual may not be held liable for the debt owed on a medical bill of an individual who is at least 18 years old unless that person has voluntarily consented to assume liability for the debt owed and the consent is (i) made on a separate document signed by the individual; (ii) not solicited in an emergency room or during an emergency situation; and (iii) not required as a condition of providing any emergency or nonemergency health care services.
14. FHH may sell a patient's debt owed to FHH for hospital services to a governmental unit or an entity that is under contract with that unit or to a nonprofit, 501(c)(3) tax-exempt organization for the sole purpose of canceling the debt as long as FHH does so in compliance with applicable Maryland law, including, without limitation, MD Code, Health-Gen. § 19-214.2 and any implementing regulations. If FHH engages in any such sale of a patient's debt, then FHH shall (i) immediately dismiss any actions pending against a patient for collection of the debt; (ii) be prohibited from engaging in collection activities on 100% of the outstanding amount of the HSCRC-set charge for the debt; (iii) be prohibited from collecting on judgments entered into on the debt; and (iv) take any additional action required by this Policy.
15. FHH/FHMG shall comply with MD Code, Health-General section 24-2502, including through this Policy's prohibition on the disclosure of medical debt to consumer reporting agencies and with respect to contracts entered into with a collection entity for the purchase or collection of medical debt.

A. RESPONSIBILITY

Bad debt "pre-list" criteria used prior to bad debt placement:

	Criteria	Other Criteria
Hospital	>\$10	Greater than 120 days from first post-discharge statement or 30 days after written notice of intent to initiate collection actions, whichever is later. Action must be reviewed by management prior to sending.
FHMG/ Professional Service	>\$5	Greater than 120 days from first post-discharge statement or 30 days after written notice of intent to initiate collection actions, whichever is later. Action must be reviewed by management prior to sending.

Small Balance Criteria:

	Criteria
Hospital	\$9.99
FHMG/Professional Service	\$4.99
Attachments	
Appendix A – Financial Assistance Sliding Scale and Federal Government Poverty Guidelines	
Appendix B – FHMG Exclusions from Financial Assistance	

Appendix A

[Financial Assistance Sliding Scale and Federal Government Poverty Guidelines](#)

See attached.

Appendix B

[FHMG Exclusions from Financial Assistance](#)

Attachments

[2025 Appendix A FA FPL Matrix Guidelines Revised 10012025.pdf](#)

[2025 Appendix B 121625.pdf](#)

[2026 Appendix A FA FPL Matrix Guidelines.pdf](#)

Approval Signatures

Step Description

Approver

Date

Senior Leader Approval

Hannah Jacobs: Senior Vice
President CFO

03/2026

Owner Approval

Shawn McCardell: Consultant

01/2026

Standards

No standards are associated with this document

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