PROPOSAL
Maryland Register
Issue Date: August 26, 2022
Volume 49 • Issue 18 • Page 822-829

Title 10
MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-214.1, and 19-214.2, Annotated Code of Maryland

Notice of Proposed Action

[22-154-P]

The Health Services Cost Review Commission proposes to amend Regulation **.26** under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at an open meeting held on May 11, 2022, notice of which was given through publication on the Commission's website under General Provisions Article, §3-302(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to have the Commission's existing regulations on Patient Rights and Obligations – Hospital Credit and Collection and Financial Assistance Policies conform to legislation enacted in the 2021 Maryland General Assembly legislative session.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The proposed amendments update the Commission's existing regulations to conform to Ch. 770, Acts of 2021. These changes will enhance protections for patients pursued by hospitals for medical debt according to their credit and collection policies. This update includes a section on new guidelines, drafted with input from a stakeholder workgroup, that hospitals will need to comply with when offering payment plans to patients. Finally, these changes will outline new reporting responsibilities for hospitals to provide more information on debt collection processes.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	**Magnitude**
D. On regulated industries or trade groups:	(-)	Indeterminable
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	(+)	Indeterminable

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D. The assumption is based on the need that hospitals may have to hire new staff or contractors to implement new procedures in compliance with the new requirements. In addition, there may be an increase in bad debt write offs.

F. The assumption is based on the belief that patients will benefit from greater access to payment plans and new medical debt collection protections.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Dennis Phelps, Deputy Director, Audit and Compliance, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2565, or email to dennis.phelps@maryland.gov, or fax to 410-358-6217. Comments will be accepted through September 26, 2022. A public hearing has not been scheduled.

.26 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies.

A. Definitions. In this regulation, the following terms have the meanings indicated.

(1) Debt Collector.

(a) "Debt collector" means a person who engages directly or indirectly in the business of:

(i) Collecting for or soliciting from another a debt owed on a hospital bill by a patient;

(ii) Giving, selling, attempting to give or sell to another, or using, for collection of a debt owed on a hospital bill by a patient, a series or system of forms or letters that indicates directly or indirectly that a person other than the hospital is asserting the debt owed on a hospital bill by a patient; or

(iii) Employing the services of an individual or business to solicit or sell a collection system to be used for collection of a debt owed on a hospital bill by a patient.

(b) "Debt collector" includes a collection agency, as defined in Business Regulation Article, §7-101, Annotated Code of Maryland.

(2) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(3) "Guidelines" means the Guidelines for Hospital Payment Plans under §B-2 of this regulation.

(4) "Initial bill" means the first billing statement provided to an individual by a hospital after the care, whether inpatient or outpatient, is provided and the individual has left the hospital facility.

(5) "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.

(6) "Payment plan" means a payment plan offered by a hospital that meets the requirements of Health-General Article, §19-214.2, Annotated Code of Maryland.

(7) Written Communications.

(a) "Written communications" includes in paper form and delivered electronically, including through electronic mail and through a secure web or mobile based application such as a patient portal.

(b) "Written communications" does not include oral communications, including communications delivered by phone.

[A.**]** *B.* Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a) Describes the hospital's financial assistance policy *as required in §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland*;

(b) (text unchanged)

(c) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i)—(ii) (text unchanged)

(iii) How to apply for **[**free and reduced-cost care**]** *financial assistance*; **[**and**]**

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill; *and*

(v) How to apply for a payment plan;

(d)—(g) (text unchanged)

(h) Informs a patient or a patient's authorized representative of the right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland, which relate to financial assistance and debt collection; **[**and**]**

(i) Provides the patient with the contact information for filing the complaint**[**.**]***;*

(j) Includes a section that allows the patient to initial that the patient has been made aware of the financial assistance policy; and

(k) Includes language explaining the availability of a payment plan.

(2) (text unchanged)

(3) The information sheet shall be provided *in writing* to the patient, the patient's family, **[**or**]** the patient's authorized representative*, or the patient's legal guardian*:

(a)—(e) (text unchanged)

(4)—(5) (text unchanged)

[A-1.**]** *B-1.* Hospital Credit and Collection **[**Policies**]** *Responsibilities*.

(1) (text unchanged)

(2) The policy shall:

(a) (text unchanged)

(b) Prohibit the charging of interest or fees on any debt owed on a hospital bill that is incurred on or after the date of service by a patient who is eligible for free or reduced-cost care under §B-2 of this regulation and Health-General Article, §19–214.1, Annotated Code of Maryland;

[(b)**]** *(c)*—**[**(d)**]** *(e)* (text unchanged)

[(e)**]** *(f)* Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care **[**on the date of service, in accordance §A-1(3) of this regulation**]**, *in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland, within 240 days after the initial bill was provided;*

[(f)**]** *(g)* If the hospital**[**,**]** has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free *medically necessary* care **[**on the date of the service for which the judgment was awarded or the adverse information was reported**]**, *in accordance with §B-2 of this regulation and Health-General Article, §19-214.2, Annotated Code of Maryland, within 240 days after the initial bill was provided,* require the hospital to seek to **[**vacated**]** *vacate* the judgment or strike the adverse information;

[(g)**]** *(h)* (text unchanged)

[(h)**]** *(i)* Provide detailed procedures for the following actions:

(i)—(iii) (text unchanged)

(iv) When a lien on a patient's or patient guarantor's personal residence, *excluding a primary resident in accordance with §B-1(9)(b) of this regulation and Health-General Article, §19-214.2(g)(2), Annotated Code of Maryland,* or motor vehicle may be placed;

(j) Prohibit the hospital from collecting additional fees in an amount that exceeds the approved charge for the hospital service as established by the Commission for which medical debt is owed on a hospital bill for a patient who is eligible for free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(k) Establish a process for making payment plans available to all patients in accordance with §B-2 of this regulation and Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland.

(3) Consistent with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, a hospital shall demonstrate that it attempted in good faith to meet the requirements of Health-General Article, §19-214.2(e), Annotated Code of Maryland, and the Guidelines before the hospital:

(a) Files an action to collect a debt owed on a hospital bill by a patient; or

(b) Delegates collection activity to a debt collector for a debt owed on a hospital bill by a patient.

(4) The hospital shall be deemed to have acted in good faith under Health-General Article, §19-214.2(e)(5)(i)(2), Annotated Code of Maryland, and §B-1(3)(b) of this regulation if, before delegating collection of a debt owed by a patient on a hospital bill to a debt collector, the hospital:

(a) Provides the information sheet before the patient receives scheduled medical services and before discharge in accordance with Health-General Article, §19-214.2(e)(1) and (2), Annotated Code of Maryland, and §B(3)(a) and (b) of this regulation; and

(b) Establishes a process for making payment plans available to all patients in accordance with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, and §B-1(2)(j) of this regulation.

(5) In delegating any or all collection to a debt collector for a debt owed on a hospital bill by a patient, the hospital may rely on a debt collector to engage in various activities, including:

(a) Facilitating and servicing payment plans in accordance with the Guidelines, including receiving and forwarding any payments received under a payment plan approved by the hospital; and

(b) Such other activities as the hospital may direct in collecting and forwarding payments under a payment plan.

(6) A hospital may not seek legal action to collect a debt owed on a hospital bill by a patient until the hospital has established and implemented a payment plan policy that complies with the Guidelines.

[(3)**]** *(7)* Beginning October 1, 2010, as provided by Health-General Article, §19-214.2(c):

(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free *medically necessary* care on the date of service;

(b) A hospital may reduce the 2-year period under **[**§A-1(3)(a)**]** *§B-1(7)(a)* of this regulation to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for

free *medically necessary* care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information; **[**and**]**

(c) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital service, a hospital shall have a refund policy that complies with the terms of the patient's plan**[.]***;*

[(4)**]** *(d)* For at least **[**120**]** *180* days after issuing an initial **[**patient**]** bill, *a hospital may not*:

(i) **[**a hospital may not report**]** *Report* adverse information about a patient to a consumer reporting agency against a patient for nonpayment;

(ii) Commence civil action against a patient for nonpayment; and

(iii) Give notice of civil action to a patient under §B-1(11) of this regulation and Health-General Article, §19-214.2(g)(3), Annotated Code of Maryland;

(e) A hospital may not report adverse information to a consumer reporting agency regarding a patient who, at the time of the service, was uninsured or eligible for free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(f) A hospital may not report adverse information about a patient to a consumer reporting agency, commence civil action against a patient for nonpayment, or delegate collection activity to a debt collector, if the hospital:

(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; or

(ii) Has completed a requested reconsideration of the denial of free or reduced-cost medically necessary care under §B-2(1)(a)(v) of this regulation and Health-General Article, §19-214.1(b)(4), Annotated Code of Maryland, that was appropriately completed by the patient within the immediately preceding 60 days.

[(5)**]** *(8) Consumer Reporting.*

(*a)* A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(b) If a hospital has reported adverse information about a patient to a consumer reporting agency, the hospital shall instruct the consumer reporting agency to delete the adverse information about the patient:

(i) If the hospital was informed by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending, and until 60 days after the appeal is complete; or

(ii) Until 60 days after the hospital has completed a requested reconsideration of the denial of free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

[(6)**]** *(9) Primary Residences.*

(a) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. **[**If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.**]**

(b) A hospital may not request a lien against a patient's primary residence in an action to collect debt owed on a hospital bill.

(10) If the hospital files an action to collect the debt owed on a hospital bill, the hospital may not request the issuance of or otherwise knowingly take action that would cause a court to issue:

(a) A body attachment against a patient; or

(b) An arrest warrant against a patient.

(11) A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect debt owed on a hospital bill if the patient is eligible for free or reduced-cost medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(12) Deceased Patients.

(a) A hospital may not make a claim against the estate of a deceased patient to collect a debt owed on a hospital bill if the deceased patient was known by the hospital to be eligible for free medically necessary care, in accordance with §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland, or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed.

(b) A hospital may offer the family of the deceased patient the ability to apply for financial assistance.

(13) A hospital may not file an action to collect a debt owed on a hospital bill by a patient until the hospital determines whether the patient is eligible for free or reduced-cost medically necessary care under §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(14) At least 45 days before filing an action against a patient to collect on the debt owed on a hospital bill, a hospital shall send written notice of the intent to file an action to the patient. The notice shall:

(a) Be sent to the patient by certified mail or first-class mail;

(b) Be in simplified language and in at least 10-point type;

(c) Include:

(i) The name and telephone number of the hospital, the debt collector (if applicable), and an agent of the hospital authorized to modify the terms of the payment plan (if any);

(ii) The amount required to cure the nonpayment of debt owed on a hospital bill, including past due payments, penalties, and fees;

(iii) A statement recommending that the patient seek debt counseling services;

(iv) Telephone numbers and internet addresses of the Health Education Advocacy Unit of the Office of the Attorney General, available to assist patients experiencing medical debt; and

(v) An explanation of the hospital's financial assistance policy;

(d) Be provided in the patient's preferred language or, if no preferred language is specified, English and each language spoken by a limited English proficient population that constitutes 5 percent of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census; and

(e) Be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance and the telephone number to call to confirm receipt of the application;

(ii) Language explaining the availability of a payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(iii) The information sheet required under §B of this regulation and Health-General Article, §19-214.1(f), Annotated Code of Maryland.

[(7)**]** *(15)* If a hospital delegates collection activity to **[**an outside collection agency**]** *a debt collector*, the hospital shall:

(a) Specify the collection activity to be performed by the **[**outside collection agency**]** *debt collector* through an explicit authorization or contract;

(b) Require the debt collector to abide by the hospital's credit and collection policy;

[(b)**]** *(c)* Specify procedures the **[**outside collection agency**]** *debt collector* must follow if a patient appears to qualify for financial assistance *under §B-2 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland*; and

[(c)**]** *(d)* Require the **[**outside collection agency**]** *debt collector* to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the **[**outside collection agency**]** *debt collector* regarding the handling of patient's bill; **[**and**]**

(ii) If a patient files a complaint with the **[**collection agency**]** *debt collector*, forward the complaint to the hospital; *and*

(iii) Along with the hospital, be jointly and severally responsible for meeting the requirements of §B-1 of this regulation and Health-General Article, §19-214.2, Annotated Code of Maryland, including the requirements enumerated in the Guidelines.

(16) A spouse or another individual may not be held liable for the debt owed on a hospital bill of an individual 18 years old or older unless the individual voluntarily consents to assume liability for the debt owed on the hospital bill. The consent shall be:

(a) Made on a separate document signed by the individual;

(b) Not solicited in an emergency room or during an emergency situation; and

(c) Not required as a condition of providing emergency or nonemergency health care services.

[(8)**]** *(17)* (text unchanged)

[(9)**]** *(18)* The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of **[**§A-1(2)**]** *§B-1(3)* of this regulation.

(19) Reporting Requirements.

(a) Each hospital shall annually submit to the Commission within 120 days after the end of each hospital's fiscal year a report including:

(i) The total number of patients, by race or ethnicity, gender, and zip code of residence, against whom the hospital or a debt collector used by the hospital filed an action to collect a debt owed on a hospital bill;

(ii) The total number of patients, by race or ethnicity, gender, and zip code of residence, with respect to whom the hospital has and has not reported or classified a bad debt; and

(iii) The total dollar amount of charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out-of-pocket costs for patients covered by insurance, and patients without insurance.

(b) The Commission shall post the information submitted under §B-1(19)(a) of this regulation on its website.

B-2. Guidelines for Hospital Payment Plans.

(1) Scope.

(a) As described in this regulation, the Guidelines apply to any payment plan offered by a hospital to a patient to pay for medically necessary hospital services after the services are provided.

(b) Prepayment Plans. The Guidelines do not apply to arrangements to make payments prior to the provision of a hospital service. Nothing in the Guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that:

(i) A hospital may not require or steer a patient to enter into such an arrangement solely to avoid the application of the Guidelines; and

(ii) Such an arrangement terminates once the hospital service is rendered.

(c) Unregulated Services. The Guidelines apply only to hospital services that are regulated by the HSCRC. The Guidelines do not apply to services that are not regulated by the HSCRC, including physician services.

(d) Limitation of the Guidelines. The Guidelines do not prevent hospitals from extending payment plans for services or at times that are outside the parameters of the Guidelines. Except as otherwise required by law or regulation, payment plans that are outside the parameters of the Guidelines are not subject to the Guidelines.

(2) Access to Payment Plans.

(a) Availability of Payment Plans. Maryland hospitals shall make payment plans available to all patients who are Maryland residents, including individuals temporarily residing in Maryland due to work or school, irrespective of their:

(i) Insurance status;

(ii) Citizenship status;

(iii) Immigration status; or

(iv) Eligibility for reduced-cost care, including reduced-cost care due to financial hardship, under this regulation.

(b) Treatment of Nonresidents. The Guidelines do not prevent a hospital from extending payment plans to patients who are not described in §B-2(2)(a) of this regulation. Except as otherwise required by law or regulation, payment plans for patients who are not described in §B-2(2)(a) of this regulation are not subject to the Guidelines.

(3) Notice Requirements.

(a) Notice of Availability of a Payment Plan.

(i) Posted Notice. A notice shall be posted in conspicuous places throughout the hospital, including the billing office, informing patients of the availability of a payment plan and whom to contact at the hospital for additional information.

(ii) Information Sheet. A written notice of the availability of a payment plan shall be contained in the information sheet required under this regulation.

(iii) Before a Prepayment Plan. Before a patient enters into a prepayment plan as described in §B-2(1) of this regulation for a medically necessary hospital service, a hospital shall provide a written notice of the availability of a payment plan to a patient.

(b) Notice of Terms Before Execution. A hospital shall provide written notice of the terms of a payment plan to a patient before the patient agrees to enter the payment plan. The terms of the payment plan shall include:

(i) The amount of medical debt owed to the hospital;

(ii) The interest rate applied to the payment plan and the total amount of interest expected to be paid by the patient under the payment plan;

(iii) The amount of each periodic payment expected from the patient under the payment plan;

(iv) The number of periodic payments expected from the patient under the payment plan;

(v) The expected due dates for each payment from the patient;

(vi) The expected date by which the account will be paid off in full;

(vii) The treatment of any missed payments, including missed payments and default as described in §B-2(10) and (14) of this regulation;

(viii) That there are no penalties for early payments; and

(ix) Whether the hospital plans to apply a periodic recalculation of monthly payment amounts as described in §B-2(9) of this regulation and the process for such recalculation.

(c) Notice of Plan After Execution. A hospital shall promptly provide a written payment plan, including items listed in §B-2(3)(b) of this regulation, to the patient following execution by all parties. The payment plan shall be provided to the patient at least 20 days before the due date of the patient's first payment under the payment plan.

(4) Income-Based Payment Plans.

(a) All payment plans shall be income-based in accordance with the Guidelines.

(b) Financial Assistance. Before entering a payment plan with a patient, a hospital shall evaluate if the patient is eligible for financial assistance, including free care, reduced-cost care, and reduced-cost care due to financial hardship, in accordance with this regulation. The hospital will apply the financial assistance reduction before entering into a payment plan with a patient.

(c) Monthly Payment Amounts. Monthly payment amounts may not exceed 5 percent of income. Under a payment plan subject to the Guidelines, a hospital may not require a patient to make total payments in a month that exceed 5 percent of the lesser of the individual patient's federal or State adjusted gross monthly income. This applies to total amounts due under the plan, including both principal and interest.

(d) Calculation of Income. A hospital shall calculate a patient's income by taking the following steps:

(i) Determining the Income Amount. If the patient has not provided their tax returns, the hospital shall use available information, including information provided by the patient, to approximate the patient's adjusted gross income. Income that is not taxable, such as certain gifts, may not be treated as income for purposes of determining the income limitation under this guideline.

(ii) Determining the Number of Filers and Dependents. The hospital shall determine the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of tax filers and dependents.

(iii) Determining the Patient's Pro-Rata Share of Income. The hospital shall divide the income amount determined under §B-2(4)(d)(i) of this regulation by the number of tax filers and dependents under §B-2(4)(d)(ii) of this regulation. This is the individual patient's income for purposes of determining the 5 percent limit on the income-based payment plans under the Guidelines.

(e) Income Documentation.

(i) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s.

(ii) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation. Such an attestation shall include the patient's income and the number of filers and dependents on their tax return.

(f) Expenses. A hospital shall consider information provided by a patient about household expenses in determining the amount of the monthly payment due under a payment plan.

(g) Application to Multiple Payment Plans.

(i) Hospitals. A hospital shall ensure that the total monthly payment amount for all payment plans provided to a patient by the hospital, when added up collectively, does not exceed the income limitation under §B-2(4)(d) of this regulation.

(ii) Hospital System. A hospital system shall ensure that the total monthly payment amount for all payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, does not exceed the income limitation under §B-2(4)(d) of this regulation.

(5) Duration of Payment Plan. The duration of a payment plan, in months, is determined 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 percent of the patients income as calculated under §B-2(4)(d) of this regulation.

(6) Interest and Fees.

(a) No Interest for Patients Eligible for Charity Care. A hospital may not charge and collect interest on the medical debt amount owed under a payment plan for patients who qualify for free or reduced-cost care, including reduced-cost care due to financial hardship, under this regulation.

(b) No Interest for Self-Pay Patients. A hospital may not charge interest on bills incurred by self-pay patients in a payment plan.

(c) Interest Allowed. A hospital may charge interest under a payment plan for a patient who is not described in §B-2(6)(a) and (b) of this regulation. A hospital is not required to charge interest for a payment plan.

(d) Interest Rate. A payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization.

(e) Timing. Interest may not begin before 180 days after the due date of the first payment.

(f) Late payments. A hospital may not charge additional fees or interest for late payments.

(7) Early payment.

(a) Prepayment Allowed. Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under a payment plan. Any prepayment made under this provision is not subject to the monthly income payment limitations of §B-2(4)(d) of this regulation.

(b) No Fees or Penalties. A hospital may not assess fees or otherwise penalize early payment of a payment plan provided by a patient.

(c) Solicitation of Early Payments Prohibited. Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in a payment plan.

(8) Limited Modifications of Payment Plans.

(a) Limitations on Payment Plan Modifications. A hospital may only modify a payment plan in the following ways:

(i) Limitation on Payment Amount. A hospital may not modify a payment plan in a way that requires a patient to make a monthly payment that exceeds the percent of the patient's income used to set the monthly payment amount under the initial payment plan as provided for in §B-2(4)(b) of this regulation.

(ii) No Increase in Interest Rate. A hospital may not increase the interest rate on a payment plan when making a modification under this guideline.

(iii) Change in Duration. The duration of a modified payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitations under §B-2(4)(b) and (d) of this regulation.

(b) Process for Modifying a Payment Plan.

(i) Prompt Response to Patient Request. If a patient requests a modification to the terms of the payment plan, the hospital shall respond 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 for a modification of the payment plan.

(ii) Reconsideration for Financial Assistance. If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance, including free care, reduced-cost care, and reduced-cost care due to financial hardship under this regulation. The hospital will apply the financial assistance reduction in its modification of the payment plan.

(iii) Change in Income. If a patient notifies a hospital that the patient's income has changed, as calculated under §B-2(4)(c) of this regulation, then the hospital shall offer to modify the payment plan to meet the requirement of §B-2(8)(a)(i) of this regulation.

(iv) Expenses. A hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

(v) Mutual Agreement. A hospital may not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.

(vi) Notice of Terms. The hospital shall provide the patient with a written notice of all payment plan terms, consistent with the requirements of §B-2(3) of this regulation, upon modifying a payment plan under this guideline.

(9) Hospital-Initiated Changes to Payment Plans Based on Changes to Patient Income.

(a) Recalculation Allowed. A hospital may, in the terms of an initial 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 subject to and calculated under this subsection.

(b) Notice Included in Initial Payment Plan. The hospital may only recalculate payment amounts under this guideline if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the payment

plan, in accordance with §B-2(3) of this regulation. The patient's agreement to enter into the payment plan after receiving that notice constitutes consent to the payment recalculations allowed under this subsection.

(c) Limitations on Modification Apply. The provisions of §B-2(8) of this regulation relating to limitations of payment plan modifications apply to payment recalculations under this subsection.

(d) Frequency of Recalculation. A hospital may not seek a recalculation of the monthly payment amount, as provided for under this subsection more often than once every 3 years.

(e) Treatment of Missing Information. If a patient does not provide income information on the request of the hospital seeking to make a change to a payment plan under this subsection and the patient is in good standing on the patient's payments under the payment plan, the hospital may not change the monthly payment amounts under the payment plan.

(10) Treatment of Missed Payments.

(a) First Missed Payment.

(i) A hospital may not deem a patient to be noncompliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period.

(ii) The hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

(iii) The hospital may consider a patient to be in default on the payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under this paragraph.

(b) Additional Missed Payments.

(i) A hospital may forbear the amount of any additional missed payments that occur in a 12-month period.

(ii) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital shall allow the patient to continue to participate in the income-based payment plan.

(iii) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital may not refer the outstanding balance owed to a collection agency or for legal action.

(iv) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this subsection as additional payments at the end of the payment plan, thereby extending the length of the payment plan.

(v) The hospital shall provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the payment plan.

(11) Treatment of Loans and Extension of Credit. After a hospital service is provided to the patient, a hospital, hospital affiliate, or third-party in partnership with a hospital may not make any loan or extension of credit to the patient that is inconsistent with the guidelines for medical debt resulting from that service.

(12) Application of Credit Provisions of Maryland Commercial Law Article. A payment plan is an extension of credit subject to Maryland credit regulations under Commercial Law Article, Title 12, Annotated Code of Maryland. Accordingly, hospitals shall elect or otherwise enter into an income-based payment plan under one of the subtitles under Commercial Law Article, Title 12, Annotated Code of Maryland. Pursuant to Financial Institutions Article, §11-302(b)(6), Annotated Code of Maryland, if a hospital is making an extension of credit through a payment plan for hospital services rendered under Commercial Law Article, Title 12, Subtitles 1, 9, or 10, Annotated Code of Maryland, and is otherwise not making loans or acting as a loan broker, then an Installment Loan License issued by the Commissioner of Financial Regulation may not be required to engage in such activity.

(13) Books and Records. A hospital shall retain books and records on payment plans for at least 3 years after the payment plan is closed.

(14) Default. If a patient defaults on a payment plan and the parties are not able to agree to a modification, then the hospital shall follow the provisions of its collection and write-off policy for the collection of debt established in accordance with this regulation, before a hospital may write this debt off as bad debt.

[A-2.**]** *B-3.* Hospital Financial Assistance Responsibilities.

[(1) Definitions

(a) In this regulation, the following terms have the meanings indicated.

(b) Terms Defined.

(i) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(ii) "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.**]**

[(2)**]** *(1)* Financial Assistance Policy.

(a) On or before June 1, 2009, each hospital and on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost *medically necessary* care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. A hospital shall provide notice of the hospital's financial assistance policy 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 hospital bill. *A patient may opt out of electronic communications by informing the hospital or debt collector orally or through written communication.* The financial assistance policy shall provide at a minimum:

(i) (text unchanged)

(ii) Reduced-cost**[**,**]** medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;

(iii) A maximum patient payment for reduced-cost *medically necessary* care not to exceed the charges minus the hospital mark-up;

(iv) A payment plan available to *all* patients **[**irrespective of their insurance status with family income between 200 and 500 percent of the federal poverty level who request assistance**]** *in accordance with the Guidelines*; and

(v) A mechanism for a patient, irrespective of that patient's insurance status, to request the hospital to reconsider the denial of free or **[**reduced**]** *reduced-cost medically necessary* care, including the address, phone number, facsimile number, email address, mailing address, and website of the Health Education and Advocacy Unit, which can assist the patient or patient's authorized representative in filing and mediating a reconsideration request.

(b) The financial assistance policy shall calculate a patient's eligibility for free medically necessary care under §B-3(1)(a)(i) of this regulation and Health-General Article, §19-214.1(b)(2)(i), Annotated Code of Maryland, or reduced-cost medically necessary care under §B-3(1)(a)(ii) of this regulation and Health-General Article, §19-214.1(b)(2)(i), Annotated Code of Maryland, at the date of service or updated, as appropriate, to account for any change in the financial circumstances of the patient that occurs within 240 days after the initial bill is provided.

[(b)**]** *(c)* A hospital whose financial assistance policy as of May 8, 2009, provides for free or reduced-cost **[**medical**]** *medically necessary* care to a patient at an income threshold higher than those set forth above may not reduce that income threshold.

[(c)**]** *(d)* Presumptive Eligibility for Free *Medically Necessary* Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free *medically necessary* care**[**, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days**]**:

(i)—(v) (text unchanged)

(vi) 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 regulation COMAR 10.37.10.26**]** *this regulation*.

[(d)**]** *(e)*—**[**(f)**]** *(g)* (text unchanged)

[(3)**]** *(2)* Each hospital shall submit to the Commission within **[**60**]** *120* days after the end of each hospital's fiscal year:

(a) (text unchanged)

(b) An annual report on the hospital's financial assistance policy that includes:

(i) (text unchanged)

(ii) The total number of inpatients and outpatients who received free *medically necessary* care during the immediately preceding year and reduced-cost *medically necessary* care for the prior year;

(iii)—(iv) (text unchanged)

(v) The total cost of hospital services provided to patients who received free *medically necessary* care; and

(vi) The **[**totalcost**]** *total cost* of hospital services provided to patients who received reduced-cost *medically necessary* care that was covered by the hospital as financial assistance or that the hospital charged to the patient.

(3) Financial Hardship Policy.

(a) Subject to **[**§A-2(b) and (c) of this regulation**]** *this subsection*, the financial assistance policy required under *§B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland,* shall provide reduced-cost**[**,**]** medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

(b) A hospital may seek and the Commission may approve a family income threshold that is different than the family income threshold under **[**§A-2(C)(1)**]** *§B-3(1)(a)* of this regulation.

(c) (text unchanged)

(d) If a patient has received reduced-cost**[**,**]** medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost**[**,**]** medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost**[**,**]** medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost**[**,**]** medically necessary care.

[(5)**]** *(4)* If a patient is eligible for reduced-cost **[**medical**]** *medically necessary* care under a hospital's financial assistance policy or financial hardship policy, the hospital shall apply the reduction in charges that is most favorable to the patient.

[(6)**]** *(5)*—**[**(7)**]** *(6)*(text unchanged)

[(8)**]** *(7)* Each hospital shall use a Uniform Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost *medically necessary* care.

[(9)**]** *(8)*—**[**10)**]** *(9)* (text unchanged)

[(11)**]** *(10)* Monetary assets excluded from the determination of eligibility for free and reduced-cost *medically necessary* care under these provisions shall be adjusted annually for inflation in accordance with the Consumer Price Index.

[(12)**]** *(11)*—**[**(13)**]** *(12)* (text unchanged)

[A-3.**]** *B-4.* (text unchanged)

[B.**]** *C.* Working Capital Differentials — Payment of Charges.

(1) A third-party payer may obtain a discount in rates established by the Commission if it provides current financing monies in accordance with the following terms**[**.**]***:*

(a)—(e) (text unchanged)

(2) The third-party payer shall promptly provide the Commission with a verified record of the detailed calculation of the current financing and of each recalculated balance as adjustments are made. The detailed calculations shall become a part of the public record. The Commission may, at any time, evaluate the amount of current financing monies provided to a hospital to assure that it meets the discount of requirements specified in **[**§B(1)**]** *§C(1)* of this regulation. If the Commission finds that the amount of current financing is inconsistent with the requirements of **[**§B(1)**]** *§C(1)*, the Commission may, at its sole discretion, require an adjustment to the working capital advance or to the discount.

(3) A payer or self-paying patient, who does not provide current financing under **[**§B(1)(a)—(e)**]** *§C(1)* of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that. *For patients who have entered into a hospital payment plan, the interest rate shall be established in accordance with the Guidelines.*

(4) (text unchanged)

(5) Hospital Written Estimate.

(a)—(c) (text unchanged)

(d) The provisions set forth in **[**§B(5)(a)—(c)**]** *§C(5)(a)—(c)* of this regulation do not apply to emergency services.

[C.**]** *D.* (text unchanged)

ADAM E. KANE
Chair
Health Services Cost Review Commission