Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

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

.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

(ii) 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) "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.

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

(5) "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.

(6) Written Communications.

(a) "Written communications" include 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 patient may opt out of electronic communications by informing the hospital or debt collector orally or through written communication.

[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-2 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)—(h) (text unchanged)

(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.

(k) Establish a process for making payment plans available to all patients in accordance with "Guidelines for Hospital Payment Plans" ("the Guidelines"), which is hereby incorporated by reference. These guidelines shall represent the Commission's official interpretation of hospital payment plan procedural requirements in accordance with 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, 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

(a) Establishes a process for making payment plans available to all patients in accordance with HG §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) (text unchanged)

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

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

(ii) A 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.

(g) 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.

(h) 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 HG §19-214.1.

(*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 HG §19-214.1, 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.

[A-2.**]** *B-2.* 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. 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-2(1)(a)(i) of this regulation and HG §19-214.1(b)(2)(i) or reduced-cost medically necessary care under §B-2(1)(a)(ii) of this regulation and HG §19-214.1(b)(2)(i) 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*ly 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**]***B*-2(3)**[**(b) and (c)**]** of this regulation, the financial assistance policy required under *§B-2 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**]***B*-2(1)*(a)***[**(c)(1)**]** 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*ly 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)

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

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

(1) (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]*C*(1) of this regulation. If the Commission finds that the amount of current financing is inconsistent with the requirements of §[B]*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**]***C*(1)(a)—(e) 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 that have entered into a hospital payment plan offered under §B-1(3)(i) of this regulation, 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**]***C*(5)(a)—(c) of this regulation do not apply to emergency services.

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

Adam Kane, Chair

Health Services Cost Review Commission