Report to the Governor: Review of Financial Assistance and Credit and Collection Activities of Maryland Hospitals

Maryland Health Services Cost Review Commission
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Table of Contents

Appendices

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I - Executive Summary

As you are well aware, Maryland is unique in that it is the only state in the nation to retain an All-Payer hospital rate setting system. This system is made possible by a federal waiver (the "Medicare Waiver") from national hospital reimbursement methods for Medicare and Medicaid, and allows for the equitable financing of hospital costs, including the reasonable costs of care to the uninsured.

In designing and operating the system, the Health Services Cost Review Commission (the "HSCRC" or "Commission") has adopted a macro-regulatory approach, establishing broad standards and financial targets for hospitals, but otherwise allowing hospital managers the flexibility they need to best meet the established regulatory targets and the needs of their communities.

This financing system provides Maryland with some unique advantages relative to hospital financing systems in the rest of the country: 1) all payers are contributing equally to the cost of Uncompensated Care ("UC"); 2) Maryland is generally recognized as providing the very best access to life-saving hospital care to the uninsured of any state in the nation; and 3) the uninsured and under-insured are charged the same rates as all other payers, when these patients often must pay three to four times Medicare allowable costs nationally.

Consistent with the HSCRC's macro-regulatory philosophy the UC funding mechanism has not differentiated between the two types of uncompensated care: charity care (free care to the very indigent) and bad debt (write offs or collections attributed to patients with the financial means to pay). As non-profit tax-exempt institutions, hospitals are expected to be responsible and judicious about when, and when not, to pursue payment.

This report is in response to your request for a thorough review of Maryland Hospital Financial Assistance and Credit and Collection policies following concerns raised about: 1) potentially overly-aggressive collection tactics; 2) wide variations in published policies, procedures, and funding levels; 3) potential inconsistencies in the application of published policies; 4) breakdowns in communication among hospitals, patients, and governmental entities leading to excessive financial hardship and emotional stress for patients otherwise meeting the eligibility standards for charity care; and 5) other inconsistencies. This report is an interim report presenting background information regarding the provision of financial assistance and application of credit and collection activities by hospitals; and evaluation of those activities relative to previously developed voluntary standards and current national trends.

The report acknowledges the somewhat conflicting goals hospitals face when attempting to both care for and collect from uninsured patients. It also attempts to identify the shared responsibilities of hospitals, patients, and regulators in addressing the identified issues and crafting workable solutions.

Overall, it appears that hospitals in the State are, for the most part, adhering to the previously established voluntary standards for financial assistance, yet disparities do exist. The State lacks any standards for Credit and Collection activities and hospitals' articulated policies are ambiguous and vary even more widely. These results are substantiated by UC funding levels and data on the provision

of Charity Care over time. Additionally it appears that hospital oversight of third-party collection agencies may not be rigorous enough to prevent unintended hardship for self-pay patients without financial means. In general, it also appears that while Maryland hospital charity care and collection practices have not changed substantially in recent years, many other states have taken regulatory and legislative steps to promote more socially conscious behavior on the part of their hospitals.

Of course hospitals must still respond to the requirements of the HSCRC (and the marketplace) that they operate efficiently and effectively, even in their credit and collection activities. Some level of aggressiveness in collection is required to counter-balance the socially irresponsible behavior of some relatively affluent patients who choose not to purchase health insurance, or who actively avoid attempts by hospitals for payment. The Commission believes that any solutions advanced must recognize the balancing act hospitals must play in meeting their multiple goals.

Finally, incentives in the rate system must be changed and regulatory oversight tightened in order to provide sufficient guidance for hospitals and their agents to change behaviors in constructive ways. The staff of the HSCRC believes that Maryland hospitals are striving to confront these multiple challenges of care delivery, mission, and solvency. And, it is up to the Commission to assist them through improved incentives and the establishment of best practice guidelines. It is only through a shared responsibility that Maryland hospitals and the regulatory system move the State to a position of leadership in these areas.

While the system is capable of making changes to address many, if not all, of these reported problems and inconsistencies, it should be recognized that in the absence of broad-based expansions in health insurance coverage, our system of UC financing (although it is the best in the nation) will remain a second best solution. We congratulate you and your Administration for taking some extremely valuable first steps in that direction last year. We encourage the State legislature, hospitals, and private and governmental payers to make similar advancements in coverage in future years.

Summary of Recommendations (discussed in more detail in section IX):

1) **Revise current Financial Assistance Eligibility Standards for the State:**

   Hospitals should provide 100 percent free hospital care to all Maryland residents who are below 200 percent of the FPL ($36,620 for a family of 3 or $44,100 for a family of 4

   Hospitals shall consider the size of a patient's bill relative to the individual's ability to pay in determining financial assistance and financial assistance option, which could include payment plans and interest-free loans.

   Requires Legislative Action

2) **Improved Communication and Notification Standards:**

   Written notice should be provided to every patient about the availability of hospital financial assistance prior to, or at discharge and hospitals shall have the responsibility to continue communications with patients throughout the entire billing and collection cycle.

   Requires Legislative Action

3) **Credit and Collection Policy changes:**

Interest and penalties should be prohibited on all bills to uninsured patients pre-judgment; this prohibition should apply to both hospitals and their third-party collection agencies; and the HSCRC should convene a Credit and Collection Work Group to develop best practice standards for Maryland hospital Collection policies and activities.

Prohibition on interest requires Legislative Action

Other recommended action can be accomplished by the HSCRC under its existing authority

4) **Compliance Oversight and Consistency:**

The HSCRC should continue to perform its special audit process; amend reporting requirements to collect additional data on bad debt recoveries; check compliance relative to notification /communication requirements; check compliance of hospitals relative to any established (best practice) guidelines for Credit and Collection activity.

Recommended action can be accomplished by the HSCRC under its existing authority

5) **HSCRC should convene a UC Work Group to consider modifications to the HSCRC UC Funding Methodology and present these recommendations to the Commission for implementation July 1, 2009;**

Recommended action can be accomplished by the HSCRC under its existing authority

6) **Continued efforts to expand the provision of health insurance coverage in the state (both private sector and governmental);**

Requires Legislative Action

7) **Continued activity and study and HSCRC to provide a complete review and report to the Governor by the fall of 2009.**

Recommended action can be accomplished by the HSCRC under its existing authority

I – Introduction

Governor's Request

This report is in response to the Governor's request for a thorough review of the credit and collection practices of Maryland acute general hospitals. Specifically, the Governor asked that the Health Services Cost Review Commission (the "HSCRC," or "Commission") evaluate these issues fully and, at a minimum, address the extent to which those policies differ across hospitals; whether hospitals have become more aggressive over time; and whether there are regulatory or legislative changes required.

Concerns Raised

The request by the Governor for this review was in response to concerns regarding the following:

1) Wide variations in the reported financial assistance and credit/collection polices of hospitals across the State;[1]

2) Potential inconsistencies in the administration of these policies and Generally Accepted Accounting Principles (GAAP) regarding the handling of bad debt recoveries;

3) Alleged insufficient regulatory oversight and increased use of aggressive collection policies by some hospitals and health systems;

4) Documented break-downs in communication between patients and hospitals and a court system that overwhelms patients;

5) Other inconsistencies and related problems (confusion of patients regarding hospital and professional-fee billing; other inconsistencies and potential illegalities – such as confusion and lack of coordination between hospital and physician billing, balance billing, billing Medicaid patients, and violations of statute of limitations).

Approach of this Review

In approaching this review, the HSCRC attempted to conduct a comprehensive and balanced review and directly address the concerns noted above. However, in doing so, there are a number of over-arching factors that should be considered.

First, while the HSCRC takes the concerns raised and the case examples cited very seriously, because of the comprehensive nature of this review there is also the need to reorganize the significant complexities and challenges facing both patients and hospitals. The issues surrounding debt collection

[1] For definitional purposes, Financial Assistance for uninsured patients is governed by policies established by hospitals for determining when patients can qualify for "free care" or "Charity Care," i.e. no payment or reduced payment for care rendered. By contrast, when a hospital determines that a patient has the ability to pay some or all of the bill, credit and collection activities of the hospital ensue. Unpaid amounts from patients in this latter category are classified as "Bad Debts." Hospital uncompensated care (UC) in the Maryland system consists of the two separate categories of unpaid bills: Charity Care and Bad Debts.

and the provision of charity care are not always as straightforward as has been discussed and reported. The problems have multiple dimensions and tradeoffs. And, while a tendency toward "macro-regulation" in the hospital rate system may have lead to unacceptable variations and inconsistencies in approach, the imposition of quick and/or rigid solutions also may have unintended and negative consequences.

Thus, in attempting to craft solutions, we should emphasize the need to share responsibility for current problems and issues with the provision and financing of uncompensated care (UC) in the health care system.

It is also important that this review consider as well larger environmental factors (such as increased scrutiny of community hospital tax-exempt status, a comparison of Maryland to hospital practices in the rest of the country, and the worsening economic environment). These factors will increase in importance over the coming years, and any identified remedies must be structured with these trends in mind.

Finally, it should also be recognized that while the Maryland system of financing hospital UC is indeed a unique one, it is clearly inferior to the first best solution of expanding insurance coverage to all citizens. With your leadership, the State made tremendous strides toward the realization of this goal this past year, but there are still many individuals who are uninsured or under-insured in Maryland. A move to comprehensive and mandated health insurance for the State, and the nation, is the ultimate solution to the issues discussed in this review and, thus, should remain our overall goal.

The following interim report and set of recommendations is provided in response to the concerns raised regarding the Financial Assistance and Credit/Collection activities of Maryland hospitals and the specific request by the Governor for a review.

III – Background: All-Payer Hospital Rate Setting System and UC Financing

All-Payer Hospital Rate Setting

As you are well aware, Maryland is unique in that it is the only state to retain an All-Payer hospital rate setting system. This system is made possible by a federal waiver (the "Medicare Waiver") from national hospital reimbursement methods for Medicare and Medicaid. State law mandating that non-governmental payers pay on the basis of HSCRC-approved rates (in conjunction with the Medicare Waiver) enables the State to continuously operate its "All-Payer" system the past 31-plus years. This unique system provides the State with some significant advantages in approaching the issue of UC financing and the provision of Charity Care to those without the means to pay for their care. The following sections provide a general description of the key characteristics of this unique regulatory and financing system.

Hospital UC Funding Mechanism

The founding statute of the HSCRC was also unique in that it identified the "reasonable cost" of hospital Uncompensated Care as a legitimate cost of doing business.[2] The HSCRC was, thus, authorized to include what it determined to be reasonable levels of hospital UC in the rates it established for all acute care general hospitals in the State.

The requirement that the funding of hospital UC be limited to reasonable levels as determined by the Commission, was an attempt to balance multiple policy goals facing the Commission. First, the funding of hospital UC was deemed important in order to support the social mission of hospitals and provide a mechanism to ensure financial access to care for all Maryland citizens. Second, this system was not intended to allow hospitals to merely pass through all uncollectable accounts. The Commission also was mandated to ensure efficient and effective operation of all Maryland hospitals, and this requirement was interpreted to extend to all areas of hospitals' business operations, including credit and collection activities. The Maryland system was structured in this fashion to avoid the problems subsequently encountered by other states (most notably New Jersey), where a pass-through of virtually all hospital UC lead to a dramatic spiraling up of the uncollectable accounts in hospital rates.[3]

In 1977, with the negotiation of the Medicare Waiver, all-payers were contributing equitably to the financing of reasonable levels of hospital UC. With the implementation of the HSCRC's Uncompensated Care pool in 1997, and the more recent introduction of full pooling of hospital UC in 2008, all payers are now paying their fair share of financing of hospital UC (some $980 million in 2008) in the State.

Mark-ups of Hospital Rates over Cost

As noted, one consequence of Maryland's All-Payer system is that all payers are contributing equitably to the financing of hospital costs, including reasonable levels of hospital UC. This is made possible through the application of a uniform markup of approved hospital rates relative to hospitals' underlying costs. The approved markup of rates over cost in Maryland is approximately 21% on average, and it includes the reasonable provision for UC, a 2% working capital advance, and other approved rate differentials.

Because of the rate setting system, Maryland traditionally has had the lowest mark-up of hospital rates (over cost) in the nation. In the absence of all-payer rate setting in the rest of the US, hospitals routinely mark-up the in charges to patients by anywhere from 70% to 300%. Data from the American Hospital Association statistics show that the average hospital markup in 2007 nationally was in excess of 170%.

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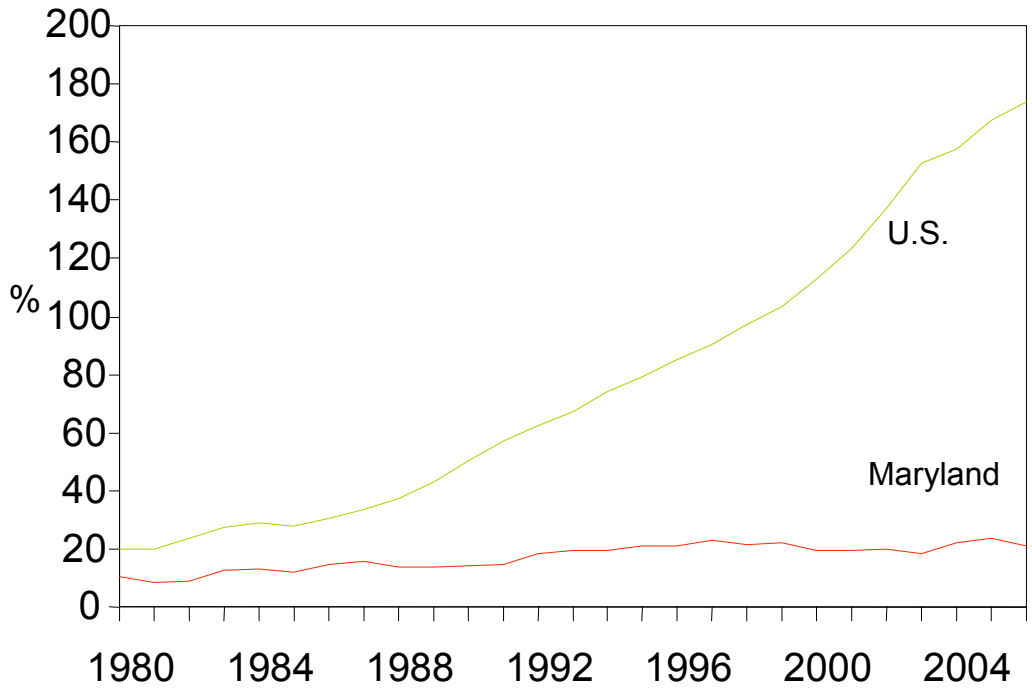
[2] Uncompensated Care in the System is defined as medical care rendered to the uninsured or underinsured and also includes debts. From the provider's perspective, the "cost" of uncompensated care is the difference between the cost of the resources used to provide the care and whatever the uninsured pay for themselves.

[3] S. Crawford, "All-Payer Financing of Uncompensated Care: The New Jersey Experience," *Bulletin of the New York Academy of Medicine* (July/August 1986): 630-636.

Exhibit 1
Hospital Markups of Charges over Cost
US vs. Maryland



Source: AHA annual survey and Maryland Rate Setting

The absence of uniform and restricted markups nationally has two important implications for the financing and accounting of hospital UC outside of Maryland. First, the excessively high markups nationally mean that the rates charged to uninsured and self-pay patients are at least 2.5 times what most health insurers pay and more than three times the Medicare allowable costs. And, these gaps between rates charged to self-pay patients and those charged to other payers continue to widen outside of Maryland, making it increasingly difficult for the uninsured to pay their hospital bills. [4] Second, the arbitrarily high markups have an impact on how non-Maryland hospitals calculate the value of the free care they provide. Most hospitals outside of Maryland calculate the value of uncompensated or free care at full charges (marked up an average of 176 percent over cost), dramatically inflating the value of this care.

Conversely, in Maryland, the value of uncompensated or free care is valued on the basis of Maryland hospitals' much lower gross charges (attributable to the lower mark-up). Because markups are regulated and applied uniformly, the uninsured are charged the same amounts as all other payers in the system. While this feature of the Maryland system does not directly impinge on the recent concerns raised about Maryland hospital collection practices, it does represent a large advantage for the State's uninsured population, which was not adequately highlighted in recent reports about the rate system.

[4] G. F. Anderson "*From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing*," Health Affairs 26, no. 3 (2007): 780–789.

Reasonable Provision for UC in Rates and Reasonable Efforts at Collection

Under the UC financing system described, hospitals do have incentives to be efficient in their collection efforts, because the level of UC afforded them is set prospectively by the Commission. This "reasonable" UC provision – or upper limit built uniformly into each hospital's rates - is determined by a straightforward formula, 50% of which is based on each hospital's three-year actual average UC, plus 50% of an amount determined by a statistical regression analysis. The regression result is specific to each hospital and is based on data that reflect the characteristics of the hospital's patient population.

Exhibit 2
Example of UC Policy Resulting from UC Formula and Establishment of Reasonable UC in Rates

(50% x 3 year average hospital actual UC) + (50% x hospital specific regression result) =
Individual Hospital UC provision for a given year

Hospital A has experienced actual UC 2005, 2006 and 2007 as a percentage of gross revenue of 5%, 6%, and 7% respectively, and regression result (or "fitted value") for the hospital is 7% -- that hospital's UC provision for 2008 (FY 2009) would be:

(50% x (5% + 6% + 7%)/3) + (50% x 7%) = 3% + 3.5% = 6.5% of gross revenue

The impact of establishing the resulting hospital-specific UC provisions prospectively (in the hospital's rates at the beginning of the year) is that if hospitals do a poor job of collecting from uninsured patients with the ability to pay, these hospitals will lose relative to UC amounts built into rates. Conversely, if they are efficient in their credit and collection activity and thereby lower their actual UC experienced, they will generate surpluses. Hospital UC has been financed in Maryland in this fashion since 1974.

The policy intent of the HSCRC's UC funding methodology is to balance the need to promote efficient collection activity while, at the same time, fulfill the Commission's statutory mandate to fund the reasonable costs of hospital UC. In practice, the methodology does not fund 100% of hospital UC, nor is it intended to do so, on average. In practice (over the life of the Commission), the policy has tended to under-fund hospitals when actual UC is increasing in the system (as a result of coverage reductions or deteriorating economic conditions), and over-fund hospitals' actual hospital UC. Over the past five years, 2003-2007 (an era characterized by relative economic prosperity and expansions in governmental coverage through the children's health initiative and the more recent State-based Medicaid expansions), the HSCRC's UC methodology funded approximately 100.4% of actual hospital UC. In previous periods, the methodology has funded less than 100% of actual UC provided.

Of course, this attempt to balance the need to ensure the hospitals remain efficient with the goal of providing adequate UC funding and financial access to care may, indeed, be undermined by instances where hospitals are overly aggressive in their attempts to collect from indigent patients. This key question of what constitutes efficient and "reasonable" collection activities is the focus of this review and will be addressed more fully in the Issues section of this document.

Macro-Regulatory Approach of the HSCRC

Implicit in most all of the Commission's regulatory activities (including its approach to the financing of hospital UC) is the concept of strong but macro-oriented regulatory oversight. What this means is that the Commission has traditionally believed it best to leave the detailed operating and resource allocation decisions up to hospital boards and management. The primary role for the Commission then has been to establish overall goals and targets for hospitals and to induce hospitals to meet these overall goals through the use of strong financial incentives. The Commission's macro-regulatory approach is also accompanied by its broad authority to collect and publish data on virtually any aspect of hospital operation and behavior. Thus, the Commission can hold hospitals accountable in meeting the desired policy goals by publishing data on hospital performance.

This philosophy of regulation stands in stark contrast to other former All-Payer regulatory systems where the rate-setting agency more actively micro-managed hospital operation by emphasizing administrative sanctions over the use of broad financial targets and incentives. An important observation is that rate systems that erred on the side of high levels of regulatory intervention eventually became less responsive to changes in the industry, experienced regulatory grid-lock, and ultimately failed.

The main advantage of the macro–regulatory approach is also potentially a disadvantage. The flexibility provided in macro-regulation allows hospitals and hospital managers the flexibility to make resource allocation decisions themselves. This adds to the overall responsiveness and effectiveness of the system. However, this flexibility can also enable behaviors that are less consistent with the goal of promoting and requiring reasonable collection efforts.

Generally, the system is self-correcting. However, in some cases over time, a more visible and targeted level of oversight and accountability may be required. The HSCRC has not hesitated to apply additional scrutiny and oversight of policies and procedures when required to ensure compliance and overall accountability.

Charity Care and Bad Debt

Consistent with the Commission's philosophy of macro-regulatory oversight, the HSCRC's UC funding methodology has never differentiated between Charity Care (free care where payment is not pursued by the hospital for patients who qualify for financial assistance) and Bad Debt (unpaid bills by patients who do not qualify for financial assistance, or who have not provided sufficient information to the hospital). The Commission has long believed that hospitals are in the best position to know the characteristics of their patients and service areas and, thus, be in the best position to establish policies and procedures governing application of financial assistance efforts and the implementation of Credit and Collection activities.

As charitable and community-based institutions – with obligations to provide benefits to the communities they serve (by virtue of their articulated community based missions and tax-exempt status) – the HSCRC long assumed that a hospital's social obligation and charitable orientation also provided compelling reasons to establish a financial assistance policy that best met the needs of its patients, in addition to collection activities that were both fair and reasonable. All but one of the State's 47 acute general hospitals in Maryland operate as non-profit (tax-exempt 501(c)(3) designation) institutions.

The general financial assistance and Credit and Collection policies and activities of Maryland hospitals are described in more detail in the sections below.

IV – Background: Hospital Financial Assistance and ("FA") Credit/Collection

Hospital Financial Assistance Policies and Activities

Based on interviews with hospital representatives and a review of published policies, it appears that Maryland hospitals' financial assistance policies vary considerably. However, the steps involved in administering these policies appear to be relatively consistent across facilities.

Generally, patients who are classified as uninsured or self-pay are first contacted in person (for most inpatients) by hospital counselors or other representatives of the hospital during or after the course of their treatment and while they are still in the hospital. For outpatients, these contacts are usually made by phone after a patient has left the hospital.

Notice of the availability of hospital financial assistance is posted, conspicuously, and the actual policies are available upon request. Most hospitals have developed pamphlets that describe the policy, the qualification process, steps necessary to determine eligibility, and possible levels of assistance if eligibility is determined. In addition, there is a standardized financial assistance form that hospitals must provide each patient upon request.

FA pamphlets describe the hospital's FA policies and the steps to be taken by patients if they believe they might qualify for FA and be eligible for either free care or a reduction in the amounts owed. Qualification for FA is a function of a patient's income, assets, number of dependents, size of the bill owed and other factors. Implementation of a hospital's financial assistance policy may result in complete forgiveness of all payment obligation, partial forgiveness and the establishment of a payment plan, or the establishment of a long term payment plan to pay off the entire balance.

Based on preliminary demographic and financial information received from patients early in the process, they are classified into one of 4 or 5 categories:

1) patient may be eligible for financial assistance and/or Medical Assistance eligibility;

2) patient is likely only eligible for financial assistance;

3) patient may be eligible for some payment reduction or extended payment plan per the financial assistance policy;

4) patient appears able to pay all or most of the bill; and

5) patients for whom insufficient information has been provided to make any of the previous determinations.

For patients in category 1 (may be eligible for Medical Assistance or financial assistance), hospitals focus primarily on qualifying the patient for Medicaid. This process requires that the hospital actively

engage the patient directly – usually by assigning a Medicaid caseworker to follow-up with the patient, complete all forms, and provide necessary information required to determine Medicaid Eligibility. It is important that this process be exhausted prior to advising to category 2 (a focus on qualifying patients for financial assistance only) because Medicaid coverage for the patient is most advantageous for all parties involved (including the State as a whole given the current federal match on State Medicaid expenditures (Federal Financial Participation or "FFP"). The most socially responsible outcome for the patient, the hospital, and the State as a whole is to qualify as many eligible patients for the Medicaid program as possible.

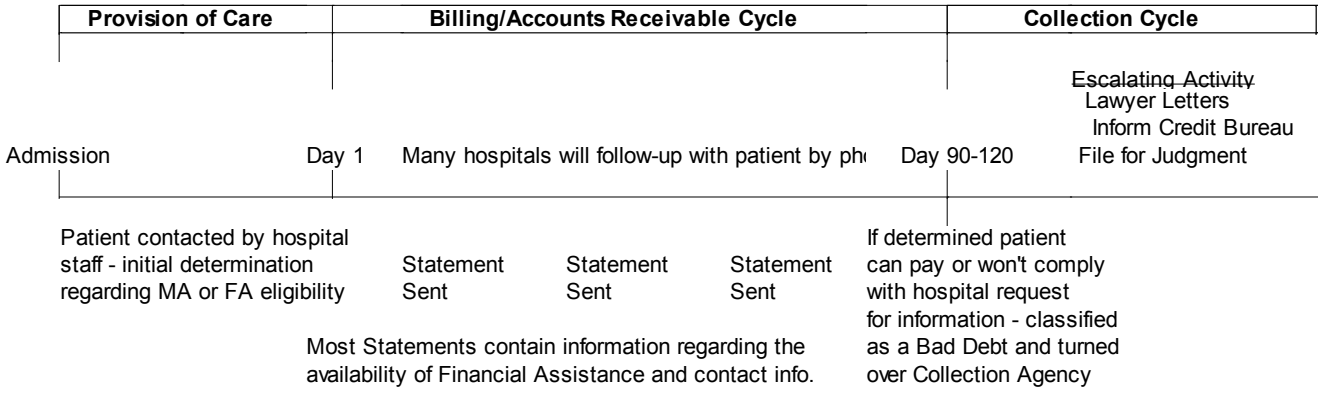
Often, the time period to determine MA eligibility can run from six to nine months. During this period, the patient is classified as "MA pending" and removed from the normal accounts receivable ("AR") cycle.

As noted, hospitals have significant incentive to qualify as many indigents for MA as possible, and they expend considerable financial resources to do so (see 2006 and 2009 Credit and Collection surveys performed by the HSCRC in **Appendix IV)**.

Often, patients are reluctant to volunteer the detailed demographic and financial information required by the MA eligibility process, and they may immediately wish to be qualified for the hospital's financial assistance policy because it is less rigorous. The ability to complete the review for categories 2 and 3 (related to financial assistance eligibility) is also often hampered by the inability or unwillingness of patients to provide the needed demographic and financial information.

The billing and accounts receivable for this phase of the collection cycle generally runs from day 1 post discharge through day 90. During this 90 day period, periodic billing statements are sent out to patients with information on how a patient may initiate a financial assistance determination. During this period, if patients are not determined to be eligible for MA, the bill is classified as a Bad Debt and turned over to a Collection Agency. This billing cycle is illustrated by the following chart:

Exhibit 3
Typical Billing and A/R Cycle for Maryland Hospitals



The HSCRC does not regulate Maryland hospitals' Financial Assistance policies. As stated, eligibility for free care or reduced payment is a function of patient (and/or household) income; availability of assets; the size of the patient's bill relative to income; and number of household dependents. The Maryland Hospital Association, however, has established voluntary minimum standards and guidelines for determining eligibility:

MHA Minimum Eligibility Standards and Program Guidelines

1. Hospitals will make financial assistance available on a sliding scale up to at least 200 percent of Federal Poverty Level (FPL);

2. Hospitals will provide 100 percent free hospital care to all Maryland residents who are below 150 percent of the FPL and have less than $10,000 in net assets;

3. Hospitals will consider the size of a patient's bill relative to the individual's ability to pay in determining financial assistance and financial assistance options, which could include payment plans and interest-free loans;

4. Hospitals will grant financial assistance for necessary hospital services;

5. Financial assistance will be provided to individuals and families who properly document eligibility and who cooperate with applying for financial assistance programs for which the hospital believes they are eligible based on the financial information provide .

These provisions are meant to be basic guidelines for hospitals and do not provide an all-inclusive exhaustive list of associated procedures and provisions. For instance, some hospitals voluntarily impose time limitations for patients in returning completed financial assistance applications and for completing the financial assistance determination process. Deadlines and timeframes of this nature can be helpful in ensuring a sharing of responsibilities and a responsive approach to financial assistance and MA eligibility determination.

The complete description of MHA voluntary standards and guidelines for Maryland hospital financial assistance is provided in **Appendix III**.

Mandated Collection of Financial Assistance Policies and use of Standardized Form

With the passage of HB 627 during 2005 Maryland legislative session, each hospital was mandated to develop its own financial assistance policy for providing free care and reduced cost care to low income individuals who lack health care coverage. In addition, the legislation required the development of a common financial assistance form to be utilized by all hospitals, and that each hospital make its financial assistance policy and the common financial assistance form available to patients upon request. These are the only mandated requirements for Maryland hospitals related to the provision of Financial Assistance.

Consistency of procedures with stated policies is checked through the application of the HSCRC's special audit process (see Section VI – Discussion Issue 4 of this report for a general description of the special audit) and also by individual and internal audits of hospital business practices.

Other Options for Linking Self-Pay Patients to Coverage

As noted, before the application of Financial Assistance policies and procedures for uninsured or self-pay patients, hospitals first attempt to qualify these patients for Medical Assistance and coverage through Maryland's Medicaid program.

Other coverage options available to uninsured patients are somewhat limited but may apply if the patient is "medically uninsurable" (patients with pre-existing conditions for which the cost of private insurance is prohibitive). Maryland citizens falling into this category can enroll comprehensive health insurance coverage administered by the Maryland Health Insurance Plan (MHIP) and pay a subsidized insurance premium. Some Maryland hospitals, in conjunction with local health agencies, have instituted a program of paying either a portion of, or all of this premium, for certain categories of patients in their service area.

Additionally, some Maryland hospitals have arrangements with county governments to extend coverage for certain categories of patients and certain services. Examples of county-based programs to expand coverage to gray-area or uninsured populations include the Healthy Howard Initiative in Howard County and the Montgomery County Maternity Partnership Program.

These efforts illustrate the fact that it is in the interest of hospitals to do whatever it can to qualify patients for available governmental or other coverage options and otherwise take steps to ensure access to care for all Maryland citizens. Hospitals spend considerable resources attempting to maximize these insurance options. When these coverage options are not available, hospitals uniformly state that it is in their interest to attempt to qualify the patient for Financial Assistance.

Maryland Hospital Credit and Collection Policies and Activities

Maryland hospitals' written policies on how to collect a debt owed to them by a patient vary widely, with some hospitals having a single policy contained within a few pages, to hospitals and multiple policies and many pages each.[5]

As noted above, hospitals attempt to obtain either Medical Assistance or Financial Assistance for qualifying patients after services are provided. Maryland hospital representatives uniformly believe that it is to their advantage to get some type of coverage or payment plan established for the patient as soon as possible. Hospitals all indicate that they make that financial assistance available to patients throughout the entire debt collection cycle (even up until a case is approved for court action).

Debt Collection Cycles

There are generally three cycles of debt collection. The first cycle, when debts are classified as accounts receivable, is typically conducted by the hospital and lasts approximately 90-120 days. A number of hospitals use outside vendors during this phase of the collection cycle. In this stage, a patient receives statements and phone calls, with the focus on helping the patient understand his/her bill and to work on receipt of payment. Interest is not typically charged on patients bills during this stage.

[5] Individual hospital credit and collection policies are available for public review at the HSCRC's offices. Interested parties should contact the HSCRC to either review in person or receive copies of hospital policies of interest.

If a patient is unresponsive to the cycle described above, patient accounts will be referred to a collection agency contacted by the hospital. Some hospitals will not refer patients to a collection agency if a patient is attempting to pay the bill; others will send all accounts to a collection agency based primarily on a set number of days following the patient's discharge from the hospital. Most hospitals will set up interest-free payment plans of up to two years. If patients miss or are late in payment, they will generally be referred to a collection agency.

There are two additional stages of collection activity involving collection agencies, which vary in terms of the level and type of aggressive collection activities pursued. These two phases involve the use of an outside vendor or collection agency.

Hospitals have the ability to "shop" for collection agencies based on the agency's personality and approach to collections – some agencies are more customer service-oriented, while others are more aggressive. Maryland hospitals appear to choose agencies that only conduct health care collections. Based on survey results, it appears that payment plans established by collection agencies can incur interest; the interest rate depends on whether the patient is in the second cycle or the more aggressive third cycle.

Hospitals classify accounts as bad debt when they are turned over to a collection agency. Some hospitals may write off a bill to bad debt immediately after it has been incurred if the patient has a previous history of non-payment (e.g., the last three inpatient stays were also reported as bad debt). Other hospitals put all bills through the full cycle, regardless of a patient's history.

While a debt is at the collection agency, hospitals may permit the debt to be noted on a patient's credit report. Hospitals will generally wait a period of time before allowing a note to be placed on the patient's credit report. Asset checking by either the hospital or the collection agency may involve paying a service or database to conduct a search for a patient's property, debts, credit history, and overall availability of assets. When an account is determined to be uncollectible due to the existence of insufficient assets, some hospitals will re-classify the account as charity care, while others leave the account as bad debt.

When an agency is unsuccessful at collecting, and finds that a patient does have available assets with which to pay the bill, it may recommend that the hospital take legal action. Pursing legal action means that the hospital will ask a court to order the bill to be paid. While hospitals report that they rarely execute legal action, such steps may include garnishment of wages, putting a lien on a patient's home, and/or a claim on an estate. Hospitals report pursuing judgments so that their interests are protected at the time a house is sold, or when a patient and his/her spouse are deceased.

Current Regulatory Oversight

Again, consistency of procedures with stated policies are checked through the application of HSCRC special audit process and also by individual and internal audits of hospital business practices.

In 2006, and more recently in 2008, the HSCRC required that hospitals submit their written policies and respond to a survey designed to further illuminate policies and procedures. The results of both surveys are contained in **Appendix IV.** Beyond these limited requests for information on practices and policies, there are no mandated or voluntary guidelines related to hospitals' credit and collection policies and activities.

Goals of the UC Financing System

Before considering the issues identified by the HSCRC for the purposes of this review, it is instructive to review the larger (and sometimes conflicting) policy goals of the HSCRC's UC financing system.

First and foremost is the goal of providing financial access to care for all Maryland citizens. Indeed, the development of a fair mechanism to pay for hospital uncompensated care was a primary reason Maryland hospitals supported the creation of rate regulation in the State in 1971.

Commensurate with this goal of access is the desire on the part of the State to support hospitals' social mission. The legislature believed that public service, including the provision of medical care to the indigent, was an essential public duty of the hospital industry. Hospitals are encouraged to service patients in need without regard to their ability to pay, and the financing of UC costs is treated as a responsibility to be shouldered by all payers. Hospitals are compensated for reasonable amounts of UC delivered through this equitable payment structure.

In carrying out this social mission, however, hospitals have an obligation to be efficient and effective in their operations. This responsibility is in keeping with the Commissions principal regulatory responsibility – to establish rates that permit efficient and effective operation.

Finally, the Commission has the responsibility to make hospitals accountable for all areas of their operations, including their commitments to their communities – e.g., reasonable debt collection activities.

There are, of course, inherent tensions between the goal of providing financial access to care for all Maryland citizens and simultaneously holding hospitals to be as efficient and effective as they can be in their collection practices. Hospitals must maintain their mission to serve while actively pursuing payment from those patients who are able to pay. It is not always clear how to best achieve the most ideal balancing of these somewhat conflicting goals, particularly in the face of the many ambiguities and complexities inherent in the billing and collection process. What is clear, however, is that patients, hospitals, and the HSCRC should all share the responsibility for achieving the most appropriate balance.

Inherent Tensions, Complexities, and Challenges

At the crux of achieving the most appropriate balancing of the above-stated goals and priorities is the question of when and under what circumstances should a particular case be treated as a "bad debt" (instances when patients can afford to pay all or part of their hospital bill), versus when and under what circumstances should a particular case be treated as charity care (instances where patients should be eligible for free care or reduced payment).

The wide variation of hospital financial assistance policies across the State is indicative of the many different ways hospitals go about attempting to answer this question. At the very least, there does appears to be a role for the HSCRC and the legislature to provide more guidance to hospitals in making these determinations.

Currently, when there are ambiguities and lack of data, the default seems to be to classify cases as bad debts. This may be due, in part, to the financial incentives in the UC funding system. Under the current system, hospitals with relatively more generous financial assistance policies are at more financial risk than those with less generous financial assistance policies. This is largely because there is no differentiation between Charity Care and Bad Debt in the current UC funding method. And, while it is in a given hospital's mission-related interest to qualify patients for financial assistance, the provision of higher proportions of charity care means the hospital has fewer opportunities to collect payment from patients and, thus, may tend to lose money relative to the amounts deemed "reasonable" and built into rates each year.

Also contributing to the challenge of arriving at a more optimal determination of bad debt versus Charity Care are the large numbers of cases and incidences. Hospitals are large and complex organizations. This issue is raised not to relieve hospitals of their need to follow procedures and policies and adhere to reasonable collection policies; rather, it is to recognize that when dealing with millions of bills ranging from $5 to $100,000 in magnitude, there will be cases that, despite the best efforts of all those involved, do fall between the cracks.

Behavior of Patients

Additionally, the issue of patient behavior and the concept of moral hazard are key factors behind the need for vigilant (yet reasonable) credit and collection activities by Maryland hospitals.

In general, "Moral Hazard" is the concept that a party insulated from risk may behave differently from the way it would behave if it were fully exposed to the risk. Moral hazard arises because an individual or institution does not bear the full consequences of its actions, and, therefore, has a tendency to act less carefully than it otherwise would, leaving another party to bear some responsibility for the consequences of those actions.[6]

In the circumstances under current review, Moral Hazard refers to instances when citizens engage in socially less desirable behaviors – applies first to individuals who refuse to purchase health insurance or adequate health insurance even though they have the financial means to do so, and then, secondly, to uninsured or underinsured individuals who receive care and then actively avoid paying the amounts they are responsible for. In the first case, the patients are healthy, and although they do assume some risk of incurring health costs should they become sick and require hospital care, they choose to ignore this risk. In the second case, after receiving care and being confronted with hospital bills, these individuals again choose to ignore these costs and the resultant activities on the part of the hospital.

The job of the hospital through the billing and collection process (and the HSCRC has created incentives for the hospital to do this) is to gradually increase the risk that patients of adequate means face until they start to bear the consequence of their actions. This is done through a gradual escalation of the collection process.

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[6] In health care, the term "Moral Hazard" is most commonly associated with behaviors that induce the inefficient use of services. For example, an individual who has subsidized health insurance may be less concerned about the health resources expended in the provisions of care because the presence of the insurance insulates that person from the cost consequences of that care.

In these circumstances, it is the responsibility of the hospitals to do the very best job they can to address this form of moral hazard and collect from these individuals. The more hospitals are limited in their ability to escalate and pursue more aggressive collection methods, the fewer tools they have at their disposal to extract payment from those with the ability to pay. Ultimately then, additional bad debts will flow into the overall cost of hospital care that we all pay.[7]

Absence of Information about the Patient

Another significant problem that hospitals face in determining eligibility for financial assistance is related to a tendency on the part of many patients to resist attempts to gather the information necessary to verify an inability to pay their bill. In many instances, the hospital suspects that a patient is eligible for financial assistance, but for a variety of reasons patients choose not to provide the information sufficient for the hospital to make that determination.

It is clear from conversations with all parties interviewed (hospitals, Legal Aid, office of the Attorney General Health Education and Advocacy Unit, government officials, and collection agency representatives) many patients without the means to pay simply refuse to provide the required income and asset-related information or follow the procedures to apply, or they fail even to attempt to contact the hospital's billing office to pursue the financial assistance or MA eligibility process and/or negotiate a reasonable payment plan.

Thus, hospitals are, to a large extent, caught between two very vexing sets of challenges and constraints: how can they, on the one hand, apply reasonable (yet increasingly aggressive and sometimes intimidating) methods of credit and collection to push back against the irresponsible behavior (moral hazard) of a certain class of patient, while, at the same time, not harm or inappropriately apply these tactics against infirm and highly indigent patients who otherwise would qualify for financial assistance (were it not for their refusal to provide the appropriate information).

The primary challenge of how to best differentiate these two classes of patients is at the crux of the most significant issues and problems being considered by this review.

How hospitals and the health system at large (regulators included) devise standards, mandates, and guidelines to accomplish the appropriate balancing of goals and optimize bad debt and charity care determinations is not simple. Other states that have approached this balance most effectively have crafted standards and mandates that share responsibility across hospitals, patents and regulatory bodies. These multiple responsibilities include:

- Responsibility of hospitals to approach the collection process in a responsible and reasonable manner; to be extremely pro-active with patients and aggressively engage them at all stages of the care delivery and billing process providing necessary information about available assistance and coverage options; and to oversee and exercise as much control of all aspects of the collection process (from start to finish), as possible.

[7] Another example of Moral Hazard that hospitals face relates to the issue of prospective eligibility for financial assistance. When a patient is approved eligible for financial assistance, the approval usually applies over some future period of time (e.g., three months or six months). While some prospective eligibility should be granted in order to ensure access to needed services for the uninsured and minimize administrative burdens on patients and hospitals, institutions may also seek to limit their exposure to abuse of prospective eligibility, by patients.

- Responsibility of regulatory body to provide the most appropriate incentives to promote balanced and responsible collection efforts and also to carry out the hospital's social mission; to ensure that the agreed upon requirements and guidelines are carried out in a consistent and thorough fashion; and, perhaps, also be linked into processes that facilitate communication with, and assistance to patients.

- Responsibility of patients also to act responsibly and to purchase insurance when they have the ability to do so; to act in a socially responsible fashion and comply with hospital attempts to obtain needed information to qualify for MA or financial assistance; and, finally, to actively communicate and negotiate with hospitals over reasonable payment alternatives based on what they can afford.

The Maryland Hospital Payment System has some advantages in financing care to the uninsured that other states do not enjoy. However, even this system is far from perfect, and as evidenced by the concerns raised (and this review), there are many areas where it can be improved upon. Hospitals, patients, regulatory agencies, and other governmental agencies must assume individual and collective responsibility for these problems and strive to improve the system.

The following sections describe the review efforts currently underway to help the State reach this delicate balancing of goals, priorities, and shared responsibility. It is then followed by a review of current Maryland hospitals policies and practices and an evaluation of these practices relative to trends in other states.

V - Steps and Activities Undertaken Thus Far

In response to your request, the staff of the HSCRC has undertaken a number of activities to develop a better understanding of the issues and concerns raised by performing an analysis of Maryland hospitals' financial assistance and collection policies, as well as trends in overall UC funding and Charity Care in the State.

In addition, the HSCRC is currently implementing several other review activities that are expected to be completed later this spring. These activities focus on auditing all hospitals to determine how consistently they are following their stated financial assistance and collection policies and Generally Accepted Accounting Principles with regard to Bad Debt recoveries and related expenses.

Later this winter, the HSCRC plans to undertake additional activities that may result in regulatory and policy changes to improve the incentives for the provision of financial assistance in the State, and to move all hospitals toward a set of identified "best practices" for credit and collection of unpaid bills.

These activities are described in further detailed in **Appendix I**. This preliminary review and the findings presented in Section VI of this report are based largely on the results of review and analyses undertaken in steps 1 – 6 listed below.

Review steps and activities undertaken thus far:

1) Issuance of revised regulations requiring the annual submission of hospital Credit and Collection policies ;

2) Meetings or attempted meetings with all involved parties (see **Appendix I**);

3) Review of Maryland Hospital Financial Assistance and Credit and Collection policies, and an analysis of these policies relative to current MHA guidelines and national trends;

4) Review of other states' legislation related to the expanded oversight and regulation of hospital financial assistance and credit and collection activities;

5) Review of UC funding by hospital -- 10 year analysis;

6) Review of CC and BD trends by hospital -- 10 year analysis;

Further review recently initiated – to be completed by April 2009:

7) Initiation of audits for every hospital to access proper administration of Financial Assistance and Credit and Collection procedures consistent with approved and current policies;

8) Initiation of Bad Debt recovery audits for every hospital to determine compliance with Generally Accepted Accounting Principles;

Review steps and activities now or soon to be initiated for completion by July 2009:

9) Formation of HSCRC UC policy Workgroup to examine and potentially revise the Commission's policies on UC Funding to more clearly take into consideration levels of Charity Care provided by Maryland hospitals;

10) Formation of HSCRC Collection Policy Work Group to identify best practices and establish guidelines for best practice guidelines for hospital Credit and Collection activities in the State;

11) Structured interviews with key informants (hospital board members and others) to collect information on methods and approaches to balance the competing objectives of: (a) providing charity care to people unable to pay; and (b) avoiding moral hazard by pursuing collection from people who are able to pay;

12) Evaluation and potential modification of the HSCRC's Community Benefit Report including the development of an evaluation and ranking of hospitals' level of responsiveness to identifying and fulfilling their community needs, including the adequate provision of charity care.

VI – Identified Issues and Preliminary Findings

In attempting to be responsive to your request for a thorough review, the HSCRC staff indentified the following eight primary issues for review and consideration. What follows is a discussion of each of the seven issues based on the data and analysis assembled for this interim report.

Issue 1: What is the current overall "center of gravity" of Maryland hospitals' financial assistance and credit/collection policies, and how do these central tendencies compare to any MHA's voluntary guidelines, and other benchmarks such as standards being developed in other states and nationally?

In attempting to address this question the HSCRC initiated an independent review of each hospital's financial assistance policy (regarding who qualifies for charity care) and credit and collection policy (regarding the policies on collecting bills from patients).[8]

Discussion & Findings: Review of Financial Assistance Policies

Overall Assessment Relative to MHA Guidelines

The primary guideline categories evaluated included: 1) income levels as a percent of the federal poverty level (FPL); 2) the upper threshold for income levels above which full payment was expected; and 3) identification of the availability of net assets.[9]

The analysis determined that financial assistance policies utilized by Maryland's hospitals generally conform to the minimum thresholds established in the voluntary guidelines developed by MHA for these three main categories. Yet, this is not always the case. MHA's guidelines specify that individuals who are below 150 percent of the federal poverty level should receive free care, and four hospitals set a lower standard. MHA's guidelines specify that full patient liability should not commence until a person is at or above 200 percent of the FPL, and four hospitals' policies set a lower standard. Finally, MHA's guidelines specify that a person whose "net assets" are below $10,000 should be considered medically indigent (and, therefore, should qualify for financial assistance); four hospitals' policies set a lower/more stringent threshold for assets.

This overall analysis also attempted to differentiate the financial assistance policies on the basis of hospital size. Generally, the analysis found that the hospitals with less generous policies are disproportionately the larger hospitals. For example (as displayed in table 2 below), 8.5 percent of *hospitals* fall below the MHA threshold for full pay (which affects 15.7 percent of hospital *beds)*.

[8] This independent review was performed by the Hilltop Institute with substantial assistance from Verité Consulting LLC.
[9] See **Appendix II** for details on each hospital's Financial Assistance Policy.

Table 1
Maryland Hospital Financial Assistance Policies Relative to MHA Guidelines, Percentage of Hospitals Compared to Percentage of Hospital Beds

	Eligible for Free Care		Threshold for Full Pay		Asset Test	
	Hospitals N = 47	Hospital Beds N = 10,681	Hospitals N = 47	Hospital Beds N = 10,681	Hospitals N = 47	Hospital Beds N = 10,681
Less Generous than MHA	8.5%	**11.2%**	8.5%	**15.7%**	8.5%	**10.4%**
MHA Guideline	31.9%	32.2%	14.9%	11.5%	10.6%	8.4%
More Generous than MHA	48.9%	48.0%	53.2%	55.5%	40.4%	46.7%
Not Stated	10.6%	8.6%	23.4%	17.3%	40.4%	34.5%
	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Observations Regarding Trends in Financial Assistance Policies in Other States

While Maryland's financial assistance polices are voluntary, more than a dozen states have implemented laws or regulations that establish enforceable standards for hospital financial assistance and/or collections policies. California and Illinois provide comparatively recent examples of legislative approaches that are among the most comprehensive.[10]

In addition to legislation at the state level, guidelines have been issued by several entities at the national level. The Healthcare Financial Management Association (HFMA) has issued two sets of guidelines for charity care and collections policies: one is issued from the HFMA Patient Friendly Billing Project; and a second is embedded in HFMA Principles & Practices Board Statement 15 (guidelines that address accounting and revenue recognition for charity care and bad debt, as well as financial assistance policies). The American Hospital Association (AHA) has also issued general guidelines for policies. The AHA guidelines are similar to those promulgated by MHA.

Further, the Internal Revenue Service (IRS) does not require hospitals to have specific charity care or collections policies in place as a condition of federal tax exemption, under Section 501(c) (3) status. Yet, in 2008, the IRS published a redesigned Form 990 (the annual information return that all tax-exempt organizations must file) and included in it a new Schedule H. Schedule H asks several questions regarding hospital charity care and collections policies, and these questions are instructive.

They include:

- Which patients qualify for free care (at different levels of income as measured by FPL or other recognized standards)?
- Which patients qualify for partial discounts (at different levels of income)?
- Do hospitals offer financial assistance to medically indigent patients (those who have medical bills that exceed a specified amount of household income and who do not otherwise qualify for charity care)?

[10] See **Appendix VIII** for summaries of California and Illinois legislation.

- Does the hospital consider household assets when granting financial assistance?

- How does the hospital inform patients regarding the availability of financial assistance (with examples provided)?

- Are collection policies and practices for those receiving financial assistance the same as those that apply to all other patients?

The remainder of this section of the analysis summarizes Maryland hospital financial assistance policies, element by element, and relates these standards to national benchmarks.

Income Policies

The MHA voluntary guidelines suggest that hospitals use, as a minimum, 150 percent of the FPL as the threshold for free care; anyone below 150 percent of the FPL should qualify for free care at any hospital in Maryland. The analysis found that the vast majority of hospitals meet this voluntary MHA standard. Fifteen hospitals use precisely this standard, and 23 hospitals have a higher threshold, ranging from 175 to 300 percent of the FPL (the most common figure among this group is 200 percent of the FPL). A few hospitals (five) do not state a specific income level; they address patient eligibility for free care on a case-by-case basis. A review of the submitted income policies show that four hospitals failed to meet MHA's voluntary guideline for free care. Three hospitals use a figure as low as 100 percent of the FPL.

With these few exceptions, Maryland's hospitals generally fall between 150 and 200 percent of the FPL in establishing an eligibility threshold for free care. For the higher-end threshold—the policy that establishes the full-pay expectation—MHA's voluntary guidelines utilize the figure of 200 percent of the FPL. In our analysis, we found that 7 hospitals use the MHA guideline; 20 hospitals use a percentage higher than the MHA guideline (ranging from 230 percent to 400 percent); and 5 set the upper limit not based on an FPL, but rather based on the patient's "ability to pay."[11] Twenty-seven hospitals also have a policy on "catastrophic" expenses for patients deemed "medically indigent," meaning these hospitals provide financial assistance at income levels above their ordinary standards when the size of the hospital bill is so large that it is difficult for a person even with relatively high income to pay in full.

Most hospitals' policies specify that the hospitals will use the patient's most current three months income to determine annual income. Some hospitals treat liquid assets as if these assets are income, but most hospitals do not. Some hospitals specify income deductions (e.g., ongoing medical expenses) to be made before calculating the individual's income (and then applying the income guidelines), but most policies use gross income.

[11] This typically involves calculating the amount patients can contribute after taking into account their living expenses.

Asset Test

The MHA voluntary guidelines utilize the concept of "net assets." The MHA guidelines state that a patient should have less than $10,000 in "net assets" in order to qualify for financial assistance. Twelve hospitals use that guideline, but the verbiage may be "assets" or "liquid assets" rather than "net assets."

Four hospitals set a lower limit and 19 set a higher limit. Nineteen hospitals' policies are silent on this issue. Some hospitals' policies exclude the patient's primary residence and a first car from inclusion in the asset test, while most policies do not address exclusions. There is no prevailing "center of gravity" for how Maryland hospitals go about testing for the existence of assets.

Nationally, states with legislation vary in the use of assets in determining eligibility.

- The HCAP program in Ohio uses family income only and does not consider assets.

- Illinois allows hospitals to include assets in eligibility determinations and when establishing payment plans. Illinois also has identified assets that should not be considered in eligibility determinations: including primary residence and any amounts held in a pension or retirement plan.

- California has stated that hospitals may consider monetary assets but not retirement or deferred compensation plans.

- On Schedule H, the IRS asks whether hospitals consider assets when determining eligibility for charity care.

Notifications of the Availability of Financial Assistance

The MHA voluntary guidelines suggest notifying patients about a hospital's financial assistance policy through a posted notice in the hospital (or, alternatively, by including the policy in the mailing of any invoice for payment). MHA's guidelines also suggest publishing an annual newspaper notice regarding the policy and providing information in multiple languages.

The independent review found that in general, hospitals either followed the MHA guidelines precisely or were silent on the issue of patient notification. Specifically, 29 of the hospitals' policies followed, at a minimum, the MHA's guidelines, with 3 hospitals having policies that provided additional notification to patients. We determined that 15 hospitals' policies are silent on this issue.

Notably, MHA's voluntary guidelines only suggest that a patient be notified once, with an immediate process for determination of eligibility for financial assistance. Notices about a hospital's financial assistance policy were not suggested at later stages in the process when the patient's financial situation might be different; these later points in time could include when a bill is referred to collection agency; when a court action is initiated; and when a court order is on the verge of resulting in garnishment of wages or the attachment of a lien (see the discussion on Credit and Collection Policies below).

Nationally, there is guidance available from HFMA's Patient Friendly Billing project. The ***PATIENT FRIENDLY BILLING*** ® Project is a collaborative endeavor spearheaded by HFMA, with support from the American Hospital Association, the Medical Group Management Association, providers, and other interested parties to promote clear, concise, and correct patient-friendly financial communications.

Many states have acted upon this guidance in legislation. California, Minnesota, and Illinois have communication requirements to patients, which include signage in highly visible areas, brochures/written information, and financial assistance information with patient statements. Hospitals should communicate this information to patients in a way that is easy to understand and culturally appropriate, as well as in the most prevalent languages.

In Schedule H, IRS requires hospitals to:

> Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's charity care policy. For example, state whether the organization (1) posts its charity care policy (or a summary thereof) and financial assistance contact information in admissions areas, emergency rooms, and other areas of the organization's facilities in which eligible patients are likely to be present; (2) provides a copy or summary of the policy and financial assistance contact information to patients as part of the intake process; (3) provides a copy or summary of the policy and financial assistance contact information to patients with discharge materials; (4) includes the policy or a summary of the policy, along with financial assistance contact information, in patient bills; and/or (5) discusses with the patient the availability of various government benefits, such as Medicaid or state programs, and assists the patient with qualification for such programs, where applicable.

Application Procedures

Virtually all of the hospitals' policies in Maryland included an application procedure through which a patient would apply for financial assistance, including free care. The documents that hospitals required from patients to make this determination (tax returns, pay stubs, etc.) generally are the same across hospitals, and the application forms are all similar. A few policies go farther than a mere description of the application procedure and impose a duty on the hospital to make a "preliminary determination" and "final determination" regarding a patient's eligibility for financial assistance within prescribed time periods. However, these prescribed time periods are not common. Moreover, some hospitals' policies specify an appeals procedure for patients who are denied eligibility for financial assistance, but the majority of policies are silent on this issue.

Required application procedures vary across other states. Most states allow hospitals to create their own application forms or (as in Ohio), provide a sample financial application that contains minimum required information and which hospitals can supplement.

Other states specify income documentation requirements. For example:

- California has determined that documentation shall be limited to recent pay stubs or income tax returns. California also has permitted hospitals to use third-party sources (when release is obtained from the patient) to obtain account information from financial or commercial institutions.

- Illinois states that hospitals *may* require documentation of family income, and acceptable documentation includes any one of the following: (a) copy of most recent tax return; (b) copy of most recent W-2 form and 1099; (c) copies of the two most recent pay stubs; (d) written verification from an employer if paid in cash; or (e) other reasonable forms of third-party income verification.

Regarding the decision-making process:

- Illinois recommends as a minimum standard that patients be notified in writing regarding the eligibility decision.

- California provides patients with the opportunity to appeal a charity care determination. Illinois and Minnesota are silent on the issue.

- HFMA Statement 15 advises that, "the provider must make reasonable attempts to notify the patient of the determination and make no further attempt to collect anything (except in cases where sliding-scale payments are part of a charity care policy)."

In addition, California states that the charity care determination can be made at any time in which the hospital is in receipt of information, or when the patient's financial situation changes; it is not a static, one-time only determination. HFMA Statement 15 supports this provision and states that hospitals should:

> "make every practical effort to make charity eligibility determinations before or at time of service….however determinations can be made at any time during the revenue cycle."

More recent legislation specifies patient responsibilities in the process. For example, Illinois indicates that to be considered for charity care, a patient must provide the hospital requested information (e.g., proof of income) within 30 days of the initial request. Illinois also states that patients should be encouraged to apply for financial assistance within 60 days of discharge.

California, Illinois, and Minnesota require patients to apply for existing sources of third-party coverage for which they might qualify, such as Medicare or Medicaid.

Approval of Policy

In this review, it was learned that the authorized agent of the hospital to establish financial assistance policy is generally the hospital's chief financial officer (CFO), chief operating officer (COO), or chief executive officer (CEO). Rarely is it stated in a policy that the hospital's board is to be involved. More specifically, 5 policies were signed by the hospital's director of Patient Financial Services, 15 by the

hospital's CFO or COO, 13 by the hospital's President or CEO, and only 2 by Chair of the Board of Directors. In the policies reviewed, 12 did not include the approving authority.

It should be noted that national experts are suggesting board review and approval of financial assistance and collection policies, reflecting the board's roles both as fiduciary and as community representative.

Discussion & Findings: Review of Credit/Collection Policies

It should be noted that the MHA has not developed voluntary guidelines for Credit and Collection Policies.[12] In general, the review found that these policies are silent on many key issues, and that there is a great deal more variation in this area from hospital to hospital. Most problematic, the vast majority of hospitals' policies make little or no attempt to control the behavior of third-party debt collectors who are acting as agents of the hospital to collect debts related to hospital services.

Conversion to Bad Debt

Almost all hospitals' policies in Maryland require private pay patients to pay a deposit on admission and to pay the balance of the bill on discharge, or enter into an extended payment agreement acceptable to the hospital.

In general, Maryland hospitals convert a debt into a bad debt when the obligation is in arrears for 90 days. Seventeen hospitals' policies turn a debt into bad debt at 90 days; 8 do so in under 90 days (a few hospitals convert debt into bad debt after just 60 days of non-payment); and 16 turn the bill to bad debt in over 90 days (up to 120 days). Six hospitals were silent on this issue.

Once a hospital converts an obligation into bad debt, the vast majority of hospitals in Maryland turn the bill over to a third-party debt collector—usually a collection agency or an attorney. A few hospitals' policies in Maryland specify that a third-party debt counseling service will begin working with delinquent patients before the obligation becomes a bad debt, with the goal of finding existing or potential eligibility for third-party sources of payment, identifying charity eligible patients, and establishing a payment agreement. This is a growing trend nationally. "Early out" intervention with self-pay patients (either with hospital employees or with a contracted vendor) provides additional financial counseling and customer service designed to help patients resolve their accounts.

Looking at other states, California legislation states that a hospital shall not report adverse information to a consumer credit reporting agency for nonpayment prior to 150 days after initial billing for a patient who lacks coverage and who has incurred high medical costs. The regular practice is to report the nonpayment to a credit agency when an account is placed with a third-party collection agency. Illinois legislation specifies in detail when hospitals and their agents may pursue various types of collection action.

[12] See **Appendix II** for details on each hospital's Credit and Collection Policy.

Control and Oversight of Third Party

Most Maryland hospitals' policies simply require standard boilerplate language that a reviewer might find in any contract; namely, that the third-party contractor comply with all applicable federal and state laws.

However, very few hospitals' policies in Maryland go beyond that to govern the behavior and practices of the third-parties that are hired by hospitals to collect bad debts. For example, while a few of the hospitals' policies admonish the third parties to comply with the hospital's standards, very few do. In general, once the debt is handed to a third party, the policies are silent regarding the behavior of these parties.

Maryland differs from the national trend in this respect. For example, Illinois law (HB4999) states:

> No collection agency, law firm, or individual may initiate legal action for non-payment of a hospital bill against a patient without the written approval of an authorized *hospital* employee who reasonably believes that the conditions for pursuing collection action … have been met. (emphasis added)

HB4999 also states:

> The hospital must ensure that any external collection agency, law firm, or individual engaged by the hospital to obtain payment of outstanding bills for hospital services agrees in writing to comply with the collections provisions of this Act.

The Minnesota agreement states that hospitals are to adopt a number of other specific debt collection reforms:

- They will develop zero tolerance for abusive and harassing debt collection conduct;
- They will instruct their attorneys not to petition to have a debtor arrested;
- They will periodically review contracts with debt collection agencies to ensure that they are acting within the law and the hospital's mission;
- They will ensure that all lawsuits are promptly filed in court; that service of the lawsuit upon the patient is documented; and that no default judgment is obtained against the patient until the patient has been given a fair opportunity to respond.

Interest, Late Fees, and Penalties

The vast majority of hospitals' policies in Maryland are silent on the subject of whether the third-party debt collectors may charge interest, late fees, and penalties on the balances due. Thirty-five policies are silent in this way. Seven policies clearly state that no interest, late fees, or penalties shall be applied. Five policies are the opposite and explicitly state that interest, late fees, and penalties may be collected.

Nationally, most hospitals in practice do not apply interest to outstanding medical bills, including those under a payment plan. California legislation states:

> Any extended payment plans offered by a hospital to assist patients under the hospital's charity care policy … or any other policy for assisting low-income patients with no insurance or high medical costs, in settling outstanding past due hospital bills shall be interest free.

Other states (Illinois and Minnesota) remain silent on the issue.

Reimbursement of Third-Party Debt Collectors

No Maryland hospital policy reviewed included a statement regarding the reimbursement rate for third-party debt collectors. A few policies addressed the events that would trigger a payment or used the term "contingency" in discussing the payments to the outside agents. In general, very little information was included in the hospitals' policies.

Garnishments, Attachments, and Liens

With respect to garnishing wages or attaching bank accounts after a court has ordered payment on an unpaid obligation, some policies in Maryland were specific and provided authority for third-party debt collectors to take these actions in the hospitals' names. However, a majority of hospitals were entirely silent and did not address the topic.

With respect to placing liens on property, 13 total policies in Maryland allowed third-party agents to attach liens on property, but 3 of those hospitals' policies specifically exempted the primary residence from liens. Three policies clearly prohibited the placement of any lien by a third-party, and, again, the large majority (31 hospitals) did not address the subject at all. The policies that tended to protect patients the most generally prohibited the third-party from conducting any of these activities once a court order was obtained. Instead, these policies required the third party to return the account to the hospital for execution of the court order.

Nationally, states have approached regulating legal actions differently. California legislation states that no hospital or collection agency shall garnish wages except by order of the court or conduct sale of the patient's primary residence during the life of the patient or the patient's spouse.

Illinois legislation states that legal action, including the garnishment of wages, may be taken to enforce the terms of the payment plan when there is evidence that the charity care patient has sufficient income and/or assets to meet the obligation. Illinois legislation further states that the hospital will not place a lien on the patient's primary residence if this is the patient's sole real asset unless the value of the property clearly indicates an ability to assume significant financial obligations. The hospital will not execute a lien by forcing the sale or foreclosure of a charity care patient's primary residence to pay for an outstanding medical bill.

The Minnesota agreement specifies that hospitals will not use body attachment to require the patient or responsible party to appear in court. In addition, hospitals are to direct their collection agencies to follow the hospitals' guidelines.

Contacting Debtors

The hospitals' policies in Maryland generally spelled out the procedures hospital personnel must follow in contacting patients for collection during the period of time the patient had a financial obligation, but before it had become a bad debt. In general, though, the hospitals' policies did not extend these expectations to the behavior of third-party debt collectors, who generally were free to pursue the obligations and contact debtors at their own discretion. A few hospitals extended the procedures that governed the behavior by hospital personnel to the third-party collectors. Still, this was not common.

Settlement

Almost all of the Credit and Collections Policies in Maryland gave hospital personnel the authority to negotiate payment terms with the debtor. Very few hospitals' policies, however, extended this same authority to third parties.

Nationally, the common practice is for third-party collection agencies to follow the hospital's payment plan policies even though these policies may not be well-documented in writing. In practice, some collection agencies will permit the payment plan to extend beyond the terms outlined by the hospital.

Illinois law specifies the following regarding patients' responsibilities regarding payment plans:

- To receive favorable treatment under the collection practices, charity care patients must cooperate with the hospital to establish a reasonable payment plan, which takes into account available income and assets, the amount of the discounted bill, and any prior payments.

- Charity care patients must make a good faith effort to honor the payment plans for their discounted hospital bills. They are responsible for communicating any change in their financial situation that may impact their ability to pay.

Approval of Policy

In general, the approval level for the Credit and Collection Policies in Maryland mirrored the authority of the financial assistance policies. Eleven policies were signed by the hospital's director of Patient Financial Services, 12 by the CFO, 8 by the President/CEO, and 1 by the Chair of the hospital's Board.

Comparison of Credit/Collection Survey Results 2006/2008

As noted, the HSCRC recently requested that all hospitals complete an informal survey on credit and collection practices of hospitals that completed surveys both in 2006 (when the HSCRC first collected Credit and Collection policies) and more recently this past year. The aggregated results of these two surveys are presented in **Appendix ___.** In general, the results show very little change in hospitals' collection procedures and activities.

Issue 2: Is the wide variation of policies and, in particular, the lack of guidelines or oversight of hospital collection policies indicative of too much latitude given to hospitals – and reflective of inadequate financial assistance criteria and/or overly aggressive collection strategies?

Discussion and Findings:

Comparison of the General Evaluation of Hospital Policies to UC Funding Results

As noted above, the factors contributing to over or underfunding of hospital UC are numerous and difficult to decipher. These include such things as prevailing economic trends, expansions in coverage (and selected coverage expansions such as the MCHIP program), efficiency in collections, relative generosity of financial assistance policies, and aggressive or overly aggressive credit and collection activities.

However, it does appear that the wide range of policies identified and described in the previous section (particularly in Credit and Collection) is, to a large extent, reflected in data on UC funding over the period analyzed. That is, the amount of UC funded through hospital rates less the value of actual UC provided also varies considerably across the State, with hospitals found to have less generous financial assistance policies (relative to MHA guidelines) experiencing the highest levels of "overfunding" of actual UC over time.

The 10 year analysis of trends in UC funding relative to actual UC by hospital is provided in **Appendix VI.**

Comparison of the General Evaluation of Hospital Policies to Reported Charity Care over Time

The HSCRC staff also conducted an analysis of trends in reported Charity Care ("CC") as a proportion of total actual UC over a 10 year period. This analysis was performed for the State as a whole, by individual hospital, by health system, and by category of hospital (faith-based, academic, rural, urban, and suburban).

Generally, faith-based institutions appear to provide higher proportions of Charity Care as a proportion of their total UC regardless of location. City and rural institutions (presumably largely due to the lower

average incomes of their patient populations) provide the highest proportions of UC as Charity Care. There are some notable exceptions to this trend, particularly in poor urban areas.

The HSCRC will seek to better understand these trends and better correlate both the UC funding analysis and CC proportion of actual UC analysis more closely with information regarding the individual financial assistance and credit/collection policies of Maryland hospitals.

The 10 year analysis of trends in Charity Care and Bad Debt (proportions as a percentage of total hospital UC) by hospital is provided in **Appendix VII.**

Issue 3: Are there obvious Credit and Collection activities that are unreasonable or inappropriate and should be modified or eliminated?

Discussion and Findings:

As noted above, the most notable observations about Maryland hospitals' Credit and Collection activities and policies is that a majority of hospitals are silent on many key criteria, and that there is a great deal more variation in reported information from hospital to hospital. Probably most problematic is the fact that the vast majority of hospitals' policies make no attempt to control the behavior of third-party debt collectors who are acting as agents of the hospital to collect debts related to hospital services.

Although these results are not entirely consistent with verbal representations made by hospital officials during recent meetings with HSCRC staff, the absence of descriptions documenting the degree of control or nature of the relationship and requirements imposed on collection agencies may be indicative of "laissez**-**faire" approach to the activities of third-party agencies by most Maryland hospitals.

With regard to the specific types of activities and practices pursued by collection agencies (beyond the troubling silence on overall control and oversight of agencies and the nature of the payment arrangement between hospitals and collection agencies).. ….

The major categories of activities examined included:

1) Parameters relating to the length of time after discharge and the circumstances under which a case is converted to Bad Debt;

2) The imposition of Interest, Late Fees, and Penalties;

3) Policies and practices related to Garnishments, Attachments, and Liens;

4) Procedures for Contacting Debtors;

5) Authority to negotiate settlement with Debtors.

While all of these activities play a role in facilitating the ultimate collection of unpaid bills from those with the ability to pay, it is not clear how much positive impact each of these have on curtailing Moral

Hazard-related behavior (or negative impact when applied to patients who are infirm and unable to pay).

Overall, it appears that there is certainly a role for the HSCRC to play in establishing explicit guidelines and expectations for hospital practices in the above listed areas, as well as in their oversight and control of collection agency activities.

Potential Areas of Focus for Legislative Changes this Year

Interest and other Penalties (pre-judgment)

With regard to some specific issues (as may relate to potential legislative activity this year), the issue of interest or other penalties applied pre-judgment is one of particular focus. Nationally, most hospitals do not apply interest to outstanding medical bills, including those under a payment plan. Further, in virtually all the recent interviews conducted by HSCRC staff, hospitals indicated they do not apply interest or penalties on unpaid bills prior to judgment. Despite these representations, at a minimum it does appear that these same restraints are not applied to third-party collection agencies in the State.

It appears that based on national trends and also preferred hospital practice within the State, in no circumstance should interest or other late fees be applied to patients' outstanding bills (or payment plans) either by a hospital or an agent acting on behalf of a hospital prior to the application of legal judgment on the case.

Liens on Primary Residences

Another category of collection activities that will likely be of particular focus this legislative session is that of the imposition of liens on primary residences. While some hospitals are silent on their policies and procedures regarding this subject, staff does not believe that any hospital in the State currently executes a lien by forcing sale or foreclosure of a patient's home in order to pay a hospital bill.

As discussed, other states have approached regulating legal actions differently. California legislation prohibits hospitals or collection agencies from conducting a sale of the patient's primary residence during the life of the patient or the patient's spouse. Illinois legislation further states that the hospital will not place a lien on the patient's primary residence if it is the patient's sole real asset, unless the value of the property clearly indicates an ability to assume significant financial obligations. The hospital will not execute a lien by forcing the sale or foreclosure of a charity care patient's primary residence to pay for an outstanding medical bill. The Minnesota agreement specifies that hospitals will not use body attachment to require the patient or responsible party to appear in court. In addition, hospitals are to direct their collection agencies to follow the hospitals' guidelines.

The issue of imposing a lien on a residence is, again, another tool at the disposal of hospitals to force patients who can pay to address their obligation to the hospital and help avoid additional health care costs for the broader public. In conversations with hospital management, the ability to threaten legal action or impose a lien does have an impact on reducing irresponsible patient behavior.

However the issue of imposing a lien on a residence is particularly emotional for obvious reasons (we obviously attach particular importance on home ownership in this country, and any attempt to effectively void ownership may appear to be morally unacceptable behavior to some).

Yet, differentiating among different classes of assets in the context of allowed and prohibited collection activity may well be inherently inequitable (why should one individual who chooses to invest in a house be exempt from activities that attempt to secure payment, while another individual who put the same amount of money in a bank account be completely vulnerable to these collection activities?).

The issue of whether there should be a blanket prohibition on the imposition of liens on primary residences then is not completely black and white. What is clear, however, is that there should be at a minimum, a prohibition on the ability of a hospital or collection agent to conduct the sale of a primary residence during the lifetime of the patient or the patient's spouse (as is the case in the State of California).

Issue 4: Are hospital policies and procedures (financial assistance, credit/collection, and GAAP re: handling of past BD collections) being followed consistently and appropriately?

Discussion:

Concerns have been raised over whether hospitals are implementing procedures and activities that are consistent with their stated/published policies for financial assistance and credit/collection. Concerns were also raised about whether hospitals are properly accounting for recoveries of bad debt from previous years and appropriately accounting for their collection-related expenses. The HSCRC's conducts special audits annually to ensure consistent application of the Commission's accounting and reporting requirements. This oversight applies to both issues. Because of the concerns raised, however, the Commission is conducting a more focused review to ensure appropriate hospital behavior.

Special Audit Procedures

The HSCRC staff has good reason to believe that hospitals are following their stated policies consistently, and, where applicable, they have also followed GAAP (Generally Accepted Accounting Principles) in the handling of bad debt recoveries and collection expense. These practices are checked as a matter of course on an annual basis through the HSCRC's Special Audit review.

A set of specific audit procedures prescribed by the HSCRC is performed annually at each hospital by an independent certified public accounting firm to check these procedures. This annual Audit tests the various data submitted by hospitals to the HSCRC in their: Annual Reports of Revenue; Expenses, and Volumes, Annual Wage and Salary Survey; Monthly Reports of Achieved Volumes (includes gross Patient Revenue Charged); and Quarterly Inpatient and Outpatient Uniform Hospital Discharge Abstract Data Set. In addition, audit procedures are prescribed to ascertain whether hospitals have performed particular activities in accordance with HSCRC instruction and policies, or where applicable, have followed Generally Accepted Accounting Principles (GAAP). A report summarizing the procedures performed and results achieved from this annual Special Audit is filed with the HSCRC 140 days after the end of the hospital's fiscal year.

There are significant legal and professional implications for CPA firms that do not report irregularities uncovered during the course of the HSCRC's special audit review. CPA firms are liable for damages by users of the Special Audit Report (HSCRC, or any other party) if the Report's findings are misleading or inaccurate. This of course also holds true, of course for audited financial statements.

It should be noted that these (procedural consistency and the handling of bad debt recoveries) are also checked by each hospital through a process of internal audits of business practices. Most hospitals also hire outside auditors to perform this internal review.

Background on Appropriate Handling of Bad Debt Recoveries and Related Expenses

All hospitals follow GAAP in accounting for bad debts. During the year, hospitals write off bad debts to Bad Debt Expense and reduce Patient Accounts Receivable. At the end of the year, hospitals estimate how much of the year's remaining Patient Accounts Receivable will be uncollectable and will become bad debts, based on their historical experience. The amount of the estimated bad debts associated with the remaining Patient Accounts Receivable is then written off to Bad Debt Expense and is set up as a Reserve for Uncollectable Accounts, which reduces the value of the asset Patient Accounts Receivable on the hospital's Balance Sheet. This accounting principle matches bad debt expense to the operations of the period in which patient revenue was earned.

When Bad Debts are recovered, whether in the current year or a later period, the gross amount of the recovery is off-set against the current year's Bad Debt Expense. The transaction for recoveries is as follows and illustrated in the table below: 1) the hospital's Bad Debt Expense is reduced by the gross amount of the recovery; 2) any collection agency or other collection fees are accounted for in a Collection Expense Account; and 3) the net amount of recovery increases the hospital's cash.

Table 2
Example of Proper Accounting of Bad Debt Recoveries and Recovery Expense

Patient Account - Written off	$1,000
Amount Collected by Collection Agency	$1,000
Collection Agency Expense - Booked as Collection Expense by Hospital	$ 500
Amount Remitted to Hospital by Collection Agency - Booked as Cash by Hospital	$500
Amount offset against Hospital Bad Debt Expense	$1,000

CPA firms utilize AICPA's (American Institute of Certified Public Accountants) Hospital Audit Guide in all hospital audits. One of the principal focuses of the audit guide is Patient Accounts Receivable. CPA firms determine that Reserves for Uncollectable Accounts are appropriate so that both the best estimate of the bad debt expense for the year is reflected in the operations of the year, and that the

Patient Accounts Receivables are valued as accurately as possible in the hospital's balance sheet. Also, a sample of bad debt recoveries is audited to ensure that they are off-set against Bad Debt Expense.

Current Audit Activity Undertaken

In response to the concerns raised, and in order to conclusively determine the appropriateness of hospital accounting practices, the Commission has initiated a series of more focused audits at all Maryland hospitals to:

1) determine how patients are informed of the availability of financial assistance;

2) ascertain by review of a sample of cases of patients who have applied for financial assistance, the percentage of cases in which each hospital followed its own Financial Assistance Policy;

3) ascertain by review of a sample of cases of patients who have required collection effort, - the percentage of cases in which each hospital followed its Credit and Collection Policy;

4) ascertain by review of a sample of cases of patients where recoveries of bad debts were made, the percentage of cases in which the gross amount of the recovery was not reduced by collection agency fees or other collection expenses, and whether all recoveries are applied to the hospital's bad debt expense or reserve in accordance with Generally Accepted Accounting Principles. These audit procedures are to be performed by Independent CPA firms with the results sent directly to HSCRC.

Appendix V provides an outline of the instructions and approach taken. The results from this review are expected to be available by the end of April, 2009.

Issue 5: What ways can notice and communication with patients be improved at all stages of the process (care of patient, billing cycle, collection cycle, legal activity) to reduce confusion, facilitate qualification process for Financial Assistance and/or negotiation of reasonable payment plans – while at the same time minimizing unnecessary cost and administrative burdens for hospitals? Related to this discussion of communication and notification issues is the issue of patient appeal processes and heightened consumer protection activities or assistance.

Discussion and Findings:

Notification

Although HB 627 from the 2005 legislative session required hospitals to "conspicuously post" notices of the availability of financial assistance for patients, there are no other requirements for Maryland hospitals to provide notice and/or continued communication with patients regarding the availability and applicability of financial assistance for hospital bills.[13]

As noted, the MHA guidelines suggest notifying patients about a hospital's financial assistance policy through a posted notice in the hospital (or, alternatively, by including the policy in the mailing of any invoice for payment). MHA's guidelines also suggest publishing an annual newspaper notice regarding the policy and providing information in multiple languages. Yet, it appears that 15 hospitals either do not adhere to these voluntary guidelines or fail to document their current policies.

Additionally, the voluntary guidelines only suggest that a patient be notified once, with no recommendation for a process of continuous notification (such as when the financial situation of a patient might have changed – including when a bill is referred to a collection agency; when a court action is initiated; and when a court order is on the verge of resulting in garnishment of wages or the attachment of a lien (see the discussion on Credit and Collection Policies below).

Given the reports of continued communication breakdowns, patients not being informed about their rights and potential remedies, the absence of an appeals and grievance process for the uninsured (as there is for insured patients), and the general difficulties hospitals encounter in obtaining needed financial and demographic information from patients who may qualify for MA or financial assistance, it is clear that hospitals and other parties need to significantly augment their efforts to increase and improve the level and quality of information and support provided to uninsured patients. Efforts also should be made to inform patients of their responsibilities through this process as well.

Additionally, compliance checks related to the implementation of improved communication and notification procedures will be required.

Overall, based on the concerns raised and information obtained during this review, it appears that a heightened focus on improved and more continuous information flow is required.

Patient Advocacy and Support

A number of other issues raised (regarding patient rights and remedies, such as prohibitions on balance billing, billing MA eligible or MA pending patients, confusion regarding professional-fee billing, and statute of limitation restrictions) may also be partially addressed by improved communication between patients and hospitals throughout the entire collection cycle. However, it appears that a more formalized appeals process (perhaps similar to the current appeals and grievance process for privately insured consumers - established and operated by the Maryland Insurance Administration (MIA) and the Health Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General

[13] Industry representatives reported that after the enactment of the legislation, hospitals took steps to make these postings of the availability of financial assistance more obvious and prevalent in areas where uninsured patients were most likely to present.

of Maryland) could provide significant assistance to uninsured and under-insured individuals who otherwise are not captured by primary mechanisms and find themselves overwhelmed by both the collection and legal process. In this type of structure, the HSCRC could, perhaps, play a role similar to that performed by the MIA for insurance claims regulated by the State. The HSCRC will continue to have on-going discussions regarding the desirability and feasibility of establishing such an assistance and support structure for Maryland's uninsured and underinsured patients.

Issue 6: What constitutes the most appropriate level of oversight over the establishment, approval, and monitoring of financial assistance and collection policies at hospitals? What is the role of hospital boards in overseeing the development of credit/collection and financial assistance policies and oversight to make sure these policies are crafted in harmony with the goals and responsibilities of community hospitals, best meet the needs of the communities, and are carried out consistently and fairly?

Discussion & Findings:

Based on the review of hospital financial assistance and credit and collection policies, as well as interviews conducted with hospital personnel, it appears that hospital board involvement in the establishment, approval and on-going review of these policies is quite limited.

On the one hand, hospital leadership and their boards may view these responsibilities and operational details as more appropriately delegated to management and business office personnel. However, given the heightened and growing cognizance over the responsibility of non-profit hospitals to provide sufficient justification for their tax-exempt status, it may be incumbent upon hospital trustees to take more of an active role in overseeing the development and faithful implementation of these policies. This role could include participating in the identification of factors considered and analysis conducted when a hospital establishes its financial assistance and collection policies, approving general principles for the establishment of more detailed eligibility criteria and codes of conduct in the collection process, making sure hospital employees receive proper education on the policies, assuming that the guidelines and eligibility criteria are communicated clearly to patients and community organizations working with the uninsured, and also assuring that bill collection policies do not intimidate people from seeking medical care.[14]

Given the potential negative implications of possible changes in eligibility criteria for tax-exempt status for community hospitals, boards have a fiduciary obligation to be as pro-active as they can be in these areas.

A higher level of board involvement in establishing, approving and monitoring these policies appears to be taking place in other states In Minnesota for instance (per the Hilltop/Verité review), an agreement between hospitals and the Minnesota Attorney General states that the board should be provided with details on the extent of the charity care and financial aid provided, as well as the administration of the policy, at least once annually. The Minnesota agreement also recommends that

[14] The AHA and Hospital & Health System Association of Pennsylvania (HAP) have both released guidelines to help member institutions review and clarify their policies, offering benchmarks for charity care, financial aid, billing and collection practices, and guidance for the oversight of hospital boards.

the hospital boards should determine if additional guidelines are needed. As noted, national experts are suggesting board review and approval of financial assistance and collection policies, reflecting the board's roles both as fiduciary and as community representative.

Issue 7: Are there Changes to the HSCRC's policy or Regulation (and other policies – perhaps some changes in Community Benefit requirements) that can help move the system toward a more desired range of operation and overall center of gravity in meeting the Policy Goals of the HSCRC and the State?

Discussion & Findings:

Potential Changes in HSCRC Uncompensated Care Funding Policy

The analysis regarding UC funding (and the generation of UC surpluses and shortfalls) and trends in Charity Care as a percentage of total actual UC delivered, shows that there may be a need to differentiate between Charity Care and Bad Debt in the methodology used by the Commission to establish its "reasonable" UC provision in rates for Maryland hospitals. This consideration is further supported by current environmental trends as discussed in the next section of this review.

Accordingly, the HSCRC should convene an Uncompensated Care Policy Work Group (consisting of HSCRC staff, hospital and payer representatives) in the coming months to consider ways of appropriately differentiating and encouraging the provision of Charity Care through the use of financial incentives. This review will result in recommendations to the Commission for potential modifications to the HSCRC's Uncompensated Care Policy for FY 2010 (effective July 1, 2009).

Development of Best Practice Standards and Guidelines for Hospital Credit and Collection

The absence of documentation of Credit and Collection policies and procedures, coupled with a perception that hospitals maintain what could be considered a laissez-faire level of oversight over third-party collection agencies, is cause for the HSCRC to work toward the identification and development of best practice standards and guidelines for Maryland hospitals, with particular focus on the oversight exercised by hospitals over their collection vendors.

In the coming months, the HSCRC should convene a Credit and Collection Work Group with the goal of establishing best-practice guidelines and standards for Maryland hospital credit and collection policies and procedures. This review should consider (but not be limited to) the following categories of collection activities:

1) Parameters relating to the length of time after discharge and the circumstances under which a case is converted to Bad Debt;

2) The imposition of Interest, Late Fees, and Penalties;

3) Policies and practices related to Garnishments, Attachments, and Liens;

4) Procedures for Contacting Debtors;

5) Authority to negotiate settlement with Debtors;

6) Control and Oversight of Third Party Debt Collectors;

7) Reimbursement of Third□Party Debt Collectors;

8) How and by whom Credit and Collection Policies are Approved.

It is anticipated that this review will result in recommendations to the Commission for the establishment of industry guidelines on Credit and Collection policies and activity sometime later this year.

Potential Modifications in the HSCRC Community Benefit Reporting and Evaluation of Community Benefit Performance

The HSCRC has been publishing a report on the Community Benefits ("CB") provided by Maryland hospitals every year since 2004. Recently, the HSCRC assembled an advisory group in an effort to: (1) alter reporting instructions to provide more focus on the identification and fulfillment of community health needs; (2) provide feed-back to hospitals on their performance over time; and (3) develop a means of objectively evaluating and ranking hospital community benefit activity. The provision of Charity Care, of course, is given some weight in assessing the benefits provided by hospitals for their community. The staff will explore other ways in which the provision and magnitude of Charity Care can be further assessed in the context of the CB report and subsequent evaluation.

VII - Significance of these Issues and Environmental Context

Increasing Scrutiny on the Tax-exempt status of Community Hospitals

In the past several years, the courts, Congress, and more recently, the Internal Revenue Service (IRS), have focused on tax-exempt organizations within the healthcare sector, scrutinizing hospital charity care (or hospital financial assistance), hospital collection policies, and community benefit standards. Interested parties have reported that standardization could lead to a better understanding of identifying industry strength and weaknesses in the system.[15] In the courts, federal class action lawsuits against tax-exempt hospitals nationally have prompted hospitals to review their financial assistance and collection policies. Since mid-2004, the Scruggs Law Firm has filed 65 lawsuits in 24 states against 60 hospitals. The major allegations made against non-profit hospitals include alleged aggressive collection tactics not in line with a hospital's charitable mission, and charging uninsured patients more than patients with insurance.

The IRS has also recently focused on abuses of tax exempt organizations, while engaging in several initiatives designed to improve the quality and quantity of information available to the public and the IRS. During an April 2005 Senate Finance Committee Hearing, the IRS' exempt organization (EO) enforcement efforts were discussed in light of recent increases in its budget. According to the IRS, the

[15] Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape. Price Waterhouse Coopers' Health Research Institute. P9. 2005.

EO examination budget had been increased by 21% since 2003, resulting in a 30% increase in staffing.[16]

In June 2006, the reported that the IRS had begun a wide-ranging investigation of non-profit hospitals to determine whether they are "flouting standards for tax exempt status." The IRS has also sent compliance check questionnaires to more than 550 tax-exempt hospitals, seeking detailed information about their operations and billing practices, as well as the compensation of top hospital executives.[17] In reviewing the questionnaires, the IRS could decide to conduct formal audits of some hospitals, employing a full-scale examination of the hospitals records. The current standards, which have changed little since 1969, rely on a vaguely defined concept of community benefit.[18] Before 1969, the IRS required hospitals' to provide charity care to qualify for tax exempt status. Since then, the agency has not specifically required such care, as long as hospitals provide benefits to their communities ("community benefits") in other ways – for example, by offering health fairs, screenings for cancer, providing emergency care, training doctors, and conducting medical research.[19]

In Congress, both the House and Senate have held hearings on broad topics regarding the tax-exempt status of charitable hospitals, with the Senate hearings focused specifically on oversight and reform of charitable organizations. Senator Charles Grassely (R-Iowa), in particular, has called for a tighter definition of charity care to ensure that taxpayers can have confidence that nonprofit hospitals are providing benefits commensurate with the billions of dollars in tax breaks they receive every year. Senator Grassley, a ranking minority member of the Senate Finance committee, recently released a discussion draft prepared by his staff, which proposes significant changes in the standards for tax-exempt hospitals.[20]

Deteriorating Economy and Continued Decreases in the Affordability of Health Care

Another important environmental factor to consider in evaluating and potentially changing guidelines for financial assistance and collection activities is the impact of the deteriorating economy nationally and in Maryland.

The combination of increased unemployment, reduced governmental assistance, and continued increases in the cost of health care will accelerate an already worrisome trend in the number of uninsured and underinsured citizens in the US and within the State. Accordingly, there is a heightened need to take steps to ensure continued financial access to care in the hospital rate setting system. In the absence of universal health insurance, financing uncompensated care through the rates and prices charged to other patients continues to be a second best solution to the problem of the uninsured.

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[16] Ibid, pp11-12.
[17] "I.R.S. Checking Compliance by Tax-Exempt Hospitals." New York Times. June 19, 2006, pA15.
[18] Ibid.
[19] "Nonprofit Hospitals Face Scrutiny Over Practices." New York Times. March 19, 2006, p14.
[20] Under current accounting rules (including those that apply to IRS Form 990, Schedule H), the hospitals in another state have the ability to value charity care they provide differently than hospitals in Maryland because of their much higher mark-ups of charges over cost. The comparatively low charges in Maryland are an important consideration to take into account in financial assistance policies and charity care reporting, because the relationship of charge to cost affects both the size of the invoice to patients, and the claimed charitable write-off when financial assistance is provided. This context is important to understand when examining policies and reported charity care costs in Maryland versus other states, because Maryland hospitals may argue that applying a charity care income standard from another state would disadvantage the Maryland hospital in claiming a federal tax exemption or in meeting the charity care requirements that may emerge this Congressional session.

Continued efforts to expand both private (small business) and governmental health insurance programs should also be a priority, contingent upon current and future budgetary constraints.

Potential mandates on individuals (above certain income thresholds) to purchase health insurance will also help address persistent coverage issues, moderate otherwise socially irresponsible behavior (Moral Hazard), and also reduce the need for aggressive collection practices of hospitals.

Again, the ultimate solution to the identified problems will likely include a mix of strategies and a balancing of responsibilities across all major participants in the health care system.

VIII – Concluding Observations

Based on its preliminary review of issues raised regarding Maryland hospital financial assistance and collection policies, the HSCRC staff has the following general observations:

- It is not the intent of hospitals to, in any way, cause financial or emotional hardship for individuals who are infirm and indigent and who could qualify (under a reasonable set of industry-wide criteria) for financial assistance and charity care.

- Hospitals uniformly articulate that it is not in their interests to wrongfully charge patients who are extremely sick (and, therefore, more vulnerable) and unable to pay all or part of their hospital bill.

- From a financial incentive standpoint, it is in the best interests of the hospital to qualify as many patients as possible for Medical Assistance, or if not, then for Financial Assistance, or if not, from the hospital.

- There are very strong incentives for MA qualification, but this is less the case for qualifying patients for Financial Assistance. Thus, there is a need to improve these incentives in the rate setting system.

- Hospitals believe they are following the rules appropriately, particularly for activities that are directly within the operational decision-making umbrella of the hospital.

- However, substantial variations in policies and procedures do exist, and this is substantiated by a review of performance over time. The wide range of approaches do not appear to be justified by nuances and differences in the characteristics of the different service areas or patient populations.

- Additional and revised standards (voluntary or otherwise) should be applied to help reduce this variation with an overall goal of increasing every hospital's emphasis on providing appropriate levels of charity care.

- In attempting to achieve this goal, we must not lose sight of the need to keep a sufficient level of financial incentive to encourage efficient and effective collection. We must also try to minimize the harm on indigent patients, which may result through a

concerted focus on patient engagement and communication throughout the collection process.

- Generally, hospitals in the State are currently doing the best job they can, given the incentives and guidelines before them. Our role as policymakers is to revise these incentives and standards to facilitate hospitals' ability to better meet the needs of the community, while at the same time carrying out their operations in a highly efficient and effective fashion – thereby keeping the cost of hospital as affordable as possible for all Maryland citizens.

IX - Recommended Action in the following Areas:

8) Revise current Financial Assistance Eligibility Standards for the State:

9) Hospitals should provide 100 percent free hospital care to all Maryland residents who are below 200 percent of the FPL ($36,620 for a family of 3 or $44,100 for a family of 4 – this may be a controversial level – hospitals current, voluntary level is 150% of FPL)

   Rationale: (recent and planned Medicaid expansions to 116% of FPL closes the gap between Medicaid and current 150% FPL guideline; "center of gravity" of current Maryland hospital policies is at or above the current 150% FPL guideline - but several hospitals are less generous on the absolute cut off for 100% free care and top end cut-off for full payment).

10) Hospitals shall consider the size of a patient's bill relative to the individual's ability to pay in determining financial assistance and financial assistance option, which could include payment plans and interest-free loans.

11) Individuals and families must properly document eligibility to qualify for financial assistance.

12) Once an individual qualifies for financial assistance from a hospital, guaranteed eligibility for medically necessary services for six months at that hospital unless during that six month period the patient qualifies for medical assistance, has otherwise become insured, or there is a change in the financial status of the individual.

13) Improved Communication and Notification Standards:

a) Written notice should be provided to every patient about the availability of hospital financial assistance prior to, or at discharge.

b) The written notice should be in easy-to-understand language.

c) The written notice should be available in English and additional languages as appropriate to the hospital's service area.

d) The written notice should include:

1. A description of the eligibility standards;
2. Information on where the hospital's financial assistance application can be obtained and contact information to learn more about the hospital's financial assistance program;
3. A description of the documentation the patient must supply to complete the uniform financial assistance application; and
4. A statement indicating that physician services are not included in the hospital bill and are billed separately.
5. A discussion of the responsibilities and expectations for patients in providing the necessary and requested information (in order for the hospital to qualify them for financial assistance), communicating with hospital personnel regarding any change in financial status, and otherwise exercising socially responsible behavior.

e) The written notice regarding the availability of hospital financial assistance should be made available at later stages during the collection cycle

1. When a bill is referred to collection;
2. when a court action is initiated; and
3. When a court order is on the verge of resulting in garnishment of wages or the attachment of a lien.

14) Credit and Collection Policy changes:

a) Interest and penalties should be prohibited on all bills to uninsured patients pre-judgment;

b) This prohibition should apply to both hospitals and their third-party collection agencies.

c) HSCRC should convene a Credit and Collection Work Group to develop best practice standards for Maryland hospital Collection policies and activities.

15) Compliance Oversight and Consistency:

The HSCRC should:

a) Continue to perform its special audit process;

b) Amend reporting requirements to collect additional data on bad debt recoveries;

c) Check compliance relative to notification/communication requirements;

d) Check compliance of hospitals relative to any established (best practice) guidelines for Credit and Collection activity.

16) **HSCRC should convene a UC Work Group to consider modifications to the HSCRC UC Funding Methodology and present these recommendations to the Commission for implementation July 1, 2009;**

17) **Continued efforts to expand the provision of health insurance coverage in the state (both private sector and governmental);**

18) **Continued activity and study and HSCRC to provide a complete review and report to the Governor by the fall of 2009.**

Appendices

Appendix I - Steps and Activities Undertaken Thus Far and On-going Review Activities

- **Proposed Regulations (Immediate Dec-Feb)**

    - In December proposed regulations requiring annual collection of Hospital Credit/Collection Policies and a survey summarizing key credit/collection activities

    - January proposed regulation to reduce the interest rate hospitals may charge on unpaid bills (often the basis for application of pre-judgment interest if granted by court)

- **Meetings with Involved Parties (Immediate Dec-Feb)**

    - Representatives from Legislature
    - Secretary of Health and DHMH Staff
    - AG Office of Consumer Protection
    - Representatives from Hospitals and Hospital Systems (representing 14 hospitals)
    - Maryland Hospital Association
    - Legal Aid Society
    - Credit/Collection Agency Representative
    - The Baltimore Sun did not respond to requests for meetings to follow-up on their findings

- **Review of Statues Governing Financial Assistance and Credit/Collection activities in other States (Immediate)**

    - California
    - Minnesota
    - Connecticut
    - Illinois
    - Washington State

- **Review of Trends in Maryland Hospital UC (and Bad Debt and Charity Care) by Hospital (Immediate Jan-Feb)**

    - UC funding in rates vs. actual UC provided
    - Trend in Bad Debt and Charity Care by hospital (is Charity Care decreasing or increasing over time)

- **Review and Evaluation of Maryland Hospital Financial Assistance (FA) and Credit/Collection (CC) Policies (Immediate Jan-Feb)**

- Stratification and overall evaluation of MD hospital FA policies
  - identify "center of gravity" of policies for industry
  - comparison to external benchmarks (other states/federal standards, internal HSCRC desired policy result)
  - identify appropriateness of establishing a mandated "floor" that could feasibly be applied State-wide (with additional measures to incentivize hospitals to provide higher levels of Financial Assistance beyond the "floor)

- Stratification and overall evaluation of MD hospital CC policies
  - identify "center of gravity" of policies for industry
  - comparison to external benchmarks (other states/federal standards, internal HSCRC desired policy result)
  - identify appropriateness of granting HSCRC authority to statutorily impose restrictions and/or requirements on CC activities

- **Initiation of Audits on every hospital (Short-term Feb-April)**

  - Audit procedural consistency with stated Financial Assistance and Credit/Collection Policies
  - Audit consistent and appropriate handling of Bad Debt Recoveries from prior years

- **Efforts Aimed at Improving Processes, Procedures, Communication with Patients, Informing Patients of their Rights and Remedies, and pre-empting an overwhelming Court System (Short-term February-April)**

  - Discussions with MHA and hospitals about improved notice and communication activities

  - Examination of potential establishment of an appeals process (through AG's office of Consumer Protection) and also implementation of pre-court mediation or review and how HSCRC would be involved

Future Activities

- **Review of Current HSCRC Uncompensated Care Policy and UC Funding Methodology (Short-Term Feb-May with a potential recommended change effective July 1)**

  - Modification of UC Funding in Rates - Potential for Additional Incentives for Charity Care

- **Effort at Developing and potentially enforcing hospital "best practices" credit and collection policies and more rigorous oversight of Collection Agencies**

  - Establishment of a Credit/Collection Work Group to develop – a set of state-wide standards for all aspects of collection activities

- **Efforts aimed at providing more "credit" for hospitals in the context of the Community Benefit Report, providing greater than expected levels of charity care to their communities.**

- **Potential Structured Interviews with Boards**

Appendix II – Stratification and Analysis of Maryland Hospital Financial Assistance and Credit and Collection Policies

Financial Assistance Policies - 2008

Provider Name	Prov. #	Notification Policy	No Pay Level	Full Pay Level	Asset Test	Who Signed	Catastrophic
MHA		Written in Eng & other lang; Posted or available at regist; **or** prior to sending bill to collection; Pub.ann.in a paper or pub.forum	**150%**	**200%**	**Net assets <$10,000**		
MedStar							
FRANKLIN SQUARE	0015	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
GOOD SAMARITAN	2004	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
HARBOR HOSPITAL CTR.	0034	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
MONTGOMERY GENERAL	0018	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
UNION MEMORIAL	0024	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
Hopkins							
HOWARD COUNTY	0048	MHA	150%	180%	Liquid Assets< $2,500	CFO/COO	Yes
JOHNS HOPKINS	0009	MHA	150%	180%	Liquid Assets< $2,500	CEO/Pres.	Yes
JOHNS HOPKINS / BAYVIEW	0029	MHA	150%	180%	Liquid Assets< $2,500	CEO/Pres.	Yes
Shore Health							
DORCHESTER GENERAL	0010	Not Stated	200%	300%	Not Stated	CFO/COO	Not Stated
MEMORIAL AT EASTON	0037	Not Stated	200%	300%	Not Stated	CFO/COO	Not Stated
WMHS							
MEMORIAL AT CUMBERLAND	0025	Not Stated	150%	200%	some real estate holdings	CFO/COO	Not Stated
SACRED HEART	0027	Not Stated	150%	200%	some real estate holdings	CFO/COO	Not Stated
Upper Chesapeake Health Systems							
HARFORD MEMORIAL	0006	Not Stated	150%	Not Stated	Liquid assets <$10,000	Director, PFS	Not Stated
UPPER CHESAPEAKE	0049	Not Stated	150%	Not Stated	Liquid assets <$10,000	Director, PFS	Not Stated
Dimensions Health							
GREATER LAUREL	0055	MHA	150%	300%	Net Assets <$10,000	CEO/Pres.	Yes
PRINCE GEORGE'S	0003	MHA	150%	300%	Net Assets <$10,000	CEO/Pres.	Yes
Adventist							
SHADY GROVE ADVENTIST	5050	MHA	100%	300%	Not Stated	Not Stated	Not Stated
WASHINGTON ADVENTIST	0016	MHA	100%	300%	Not Stated	Not Stated	Not Stated
Independents							
ANNE ARUNDEL	0023	MHA	200%	330%	Not Stated	Not Stated	Not Stated
ATLANTIC GENERAL	0061	Not Stated	200%	Not Stated	Not Stated	Director, PFS	Yes
BALTIMORE WASHINGTON	0043	MHA	200%	Not Stated	Not Stated	CFO/COO	Not Stated
BON SECOURS	0013	MHA	200%	Ability to Pay	Not Stated	Board Chair	Yes
CALVERT MEMORIAL	0039	Exceeds MHA	175%	230%	Net Assets <$14,000	Board Chair	Yes
CARROLL COUNTY	0033	MHA	300%	375%	Not Stated	CFO/COO	Yes
CHESTER RIVER	0030	Not Stated	200%	Not Stated	Not Stated	CEO/Pres.	Not Stated
CIVISTA	0035	MHA	200%	300%	$7,500 Cash	Not Stated	Not Stated
DOCTORS	0051	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.	Not Stated
FORT WASHINGTON	0060	MHA	Not Stated	Not Stated	Not Stated	CEO/Pres.	Yes
FREDERICK MEMORIAL	0005	MHA	200%	300%	No Liquid	Director, PFS	Not Stated
G.B.M.C	0044	Not Stated	300%	Ability to Pay	Liquid < $25,000	CFO/COO	Yes
GARRETT COUNTY	0017	MHA	150%	200%	Net Assets <$10,000	CFO/COO	Not Stated
HOLY CROSS	0004	Exceeds MHA	150%	300%	Assets<$10,000	Not Stated	Yes
KERNAN	2001	MHA	200%	Ability to Pay	Assets<$10,000	CFO/COO	Yes
MARYLAND GENERAL	0038	MHA	150%	200%	Liquid < 100% FPL	CEO/Pres.	Not Stated
Mc CREADY	0045	Not Stated	150%	200%	Assets<$10,000	CEO/Pres.	Yes
MERCY	0008	MHA	200%	400%	Net Assets <$10,000	CFO/COO	Yes
NORTHWEST HOSPITAL	0040	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.	Not Stated
PENINSULA REGIONAL	0019	MHA	Not Stated	Not Stated	Not Stated	CEO/Pres.	Not Stated
SAINT AGNES	0011	Not Stated	200%	300%	Liquid assets <$10,000	CEO/Pres.	Yes
SAINT JOSEPH'S	0007	MHA	130%	195%	Not Stated	CFO/COO	Yes
SAINT MARY'S	0028	Exceeds MHA	Not Stated	Not Stated	Not Stated	CEO/Pres.	Not Stated
SINAI	0012	MHA	200%	Ability to Pay	Not Stated	CFO/COO	Yes
SOUTHERN MARYLAND	0054	Not Stated	100%	Not Stated	Only primary resid.	Not Stated	Yes
SUBURBAN	0022	MHA	200%	200%	Not Stated	Not Stated	Yes
UNION OF CECIL	0032	Not Stated	150%	300%	Not Stated	CFO/COO	Not Stated
UNIVERSITY OF MD.	0002	MHA	200%	Ability to Pay	Assets<$10,000	CFO/COO	Yes
WASHINGTON COUNTY	0001	MHA	150%	200%	Net Assets <$10,000	Director, PFS	Yes

Credit and Collection Policies - 2008

Provider Name	Prov. #	Days to Initiation of Collection	Interest	Pay-off period (Mos.)	Garnish Attach	Lien	Who Approved Policy
Medstar							
FRANKLIN SQUARE	0015	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
GOOD SAMARITAN	2004	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
HARBOR HOSPITAL CTR.	0034	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
MONTGOMERY GENERAL	0018	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
UNION MEMORIAL	0024	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
Hopkins							
HOWARD COUNTY	0048	90	Not Stated	18	Not Stated	Estate	CEO/Pres.
JOHNS HOPKINS	0009	90	Not Stated	18	Not Stated	Estate	CEO/Pres.
JOHNS HOPKINS / BAYVIEW	0029	90	Not Stated	18	Not Stated	Estate	CEO/Pres.
Shore Health							
DORCHESTER GENERAL	0010	90	Not Stated	6	Not Stated	Not Stated	Not Stated
MEMORIAL AT EASTON	0037	90	Not Stated	6	Not Stated	Not Stated	Not Stated
WMHS							
MEMORIAL AT CUMBERLAND	0025	90	Not Stated	Not Stated	Not Stated	Not Stated	CFO
SACRED HEART	0027	90	Not Stated	Not Stated	Not Stated	Not Stated	CFO
Upper Chesapeake Health System							
HARFORD MEMORIAL	0006	68	No interest	12	YES	NO	Director, PFS
UPPER CHESAPEAKE	0049	68	No interest	12	YES	NO	Director, PFS
Dimensions Health							
GREATER LAUREL	0055	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated	CFO
PRINCE GEORGE'S	0003	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated	CFO
Adventist							
SHADY GROVE ADVENTIST	5050	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
WASHINGTON ADVENTIST	0016	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
Independents							
ANNE ARUNDEL	0023	90	No interest	Not Stated	Not Stated	Yes, Not primary res.	Not Stated
ATLANTIC GENERAL	0061	90	No interest	Not Stated	Not Stated	Not Stated	CFO
BALTIMORE WASHINGTON	0043	90	Not Stated	Not Stated	YES	YES	CFO
BON SECOURS	0013	Not Stated	If Bad Debt	8	Not Stated	NO	CFO
CALVERT MEMORIAL	0039	80	Not Stated	Not Stated	YES	YES	Board Chair
CARROLL COUNTY	0033	Not Stated	No interest	36	Not Stated	Not Stated	CFO
CHESTER RIVER	0030	60	Not Stated	Not Stated	Not Stated	Not Stated	CFO
CIVISTA	0035	60	Not Stated	Not Stated	YES	Not Stated	Director, PFS
DOCTORS	0051	120	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.
FORT WASHINGTON	0060	105	If Bad Debt	Not Stated	Not Stated	Not Stated	Not Stated
FREDERICK MEMORIAL	0005	120	Not Stated	18	Not Stated	Estate	Director, PFS
G.B.M.C	0044	90	Not Stated	Not Stated	Not Stated	Not Stated	CFO
GARRETT COUNTY	0017	120	Not Stated	Not Stated	Not Stated	Not Stated	CFO
HOLY CROSS	0004	90	No interest	6	Not Stated	Estate	Not Stated
KERNAN	2001	90	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
MARYLAND GENERAL	0038	75	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.
Mc CREADY	0045	60	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.
MERCY	0008	90	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
NORTHWEST HOSPITAL	0040	90	If Bad Debt	Not Stated	YES	YES	Not Stated
PENINSULA REGIONAL	0019	60	Not Stated	12	YES	YES	Not Stated
SAINT AGNES	0011	90	Not Stated	Not Stated	YES	Yes, Not primary res.	CEO/Pres.
SAINT JOSEPH'S	0007	120	No interest	9	Not Stated	Yes, Not primary res.	CEO/Pres.
SAINT MARY'S	0028	Not Stated	Not Stated	Not Stated	YES	YES	Not Stated
SINAI	0012	120	If Bad Debt	Not Stated	YES	Not Stated	Not Stated
SOUTHERN MARYLAND	0054	120	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
SUBURBAN	0022	120	If Bad Debt	12	Not Stated	Not Stated	Not Stated
UNION OF CECIL	0032	120	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
UNIVERSITY OF MD.	0002	90	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
WASHINGTON COUNTY	0001	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated	CFO

Source: HSCRC collected policies (with analysis performed by Hilltop Institute)

Appendix III – MHA FA Guidelines and Standards and Common Application

Eligibility Standards and Program Guidelines

1. Hospitals will make financial assistance available on a sliding scale up to at least 200 percent of Federal Poverty Level (FPL).

2. Hospitals will provide 100 percent free hospital care to all Maryland residents who are below 150 percent of the FPL and have less than $10,000 in net assets.

3. Hospitals will consider the size of a patient's bill relative to the individual's ability to pay in determining financial assistance and financial assistance options, which could include payment plans and interest-free loans.

4. Hospitals will grant financial assistance for necessary hospital services.

5. Financial assistance will be provided to individuals and families who properly document eligibility and who cooperate with applying for financial assistance programs for which the hospital believes they are eligible based on the financial information provided.

Standard Hospital Procedures Related to Financial Assistance

1. Hospitals should make written notice, such as brochures and signs, about their financial assistance policy available to a patient or family members. For example, written notices could be posted or available at registration, with the first patient bill or written patient communication, prior to sending a bill to a third party for collection, or prior to discharge. They will always be made available on request. These notices also will be published annually in a public forum, such as a local newspaper.

2. Written notices should include information on where the hospital's financial assistance policy can be obtained and a way to contact the hospital, such as a telephone number.

3. Written notices should be available in English and additional languages as appropriate to a hospital's service area.

4. Hospital employees should know how to refer a patient or family member to the appropriate location in the hospital for financial assistance information. All employees in patient financial services should understand the hospital's financial assistance policy, have access to the application forms, and be able to direct questions to the proper hospital representative.

5. Any third parties or vendors that hospitals work with in patient financial services should understand the hospital financial assistance policy and know how to refer a patient or family member to the appropriate location in the hospital for financial assistance information.

Common Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated

US Citizen: Yes No Permanent Resident: Yes No

Home Address Phone _____

_____

_____

_____

_____
City State Zip code Country

Employer Name Phone _____

_____

Work Address

_____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance		Approximate value
_____			_____
Automobile	Make _____	Year _____	Approximate value
			_____
Additional vehicle	Make _____	Year _____	Approximate value
			_____
Additional vehicle	Make _____	Year _____	Approximate value
			_____
Other property			Approximate value
			_____
		Total	
			_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes
No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true

Appendix IV – Results of Credit and Collection Surveys 2006 and 2009

HSCRC Survey on Credit and Collection Practices of Maryland Hospitals - 2006

Below are the list of questions that hospitals were asked as part of the HSCRC's informal hospital credit and collection survey, along with the percentage of responses from hospitals for simple quantitative questions.

Survey Question	Response[21]			
Internal Hospital Collection Policy				
If a patient gives no response to the hospital's collection efforts, when does the hospital refer the account to a collection agency (in days)?	**45-59**	**60-89**	**90-119**	**120+**
	4	11	15	15
If a patient agrees to a reasonable collection plan with the hospital, does this stop the timing cycle for referring a patient's account to a collection agency?[22]	**Yes**		**No**	
	45		1	
Does your hospital charge interest for payment plans for accounts in active AR? (Hospital rates and terms can be found within an individual hospital's response)	**Yes**		**No**	
	0		46	
Does your hospital bill include the following or a similar statement? "This bill is only for hospital services. You should expect a separate bill from your physician."	**Yes**		**No**	
	32		14	
Do you have a single phone number on the hospital bill that a patient can call to get their questions answered?	**Yes**		**No**	
	46		0	
If a patient has a history of previous non-payment, is the credit and collection process different? (e.g., immediate write-off to bad debt, commence full billing cycle?)	**Yes**		**No**	
	9		37	
If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's internal collection policy different (yes/no)? (Detailed explanations can be found in an individual hospital's response)	**Yes**		**No**	
	21		25	

External Hospital Collection Policy[23]		
How is the account classified once it moves to a collection agency? (e.g., bad debt?)	**Bad Debt**	**Accounts Receivable**
	45	1
While a debt is at a collection agency, is the debt permitted to be noted on a patient's credit report? If yes, please provide details (when noted on credit report, how long, etc.).	**Yes**	**No**
	30	16

[21] N=46 responses, or 48 hospitals. Easton Memorial and Dorchester General replied as one system response, Shady Grove and Washington Adventist replied as one system response. Additionally, 47 respondents are not- for-profit, one is for-profit.

[23] By external, it is meant those credit and collection policies that are handled by an outside collection agency retained by the hospital.

Who determines when an account should be considered uncollectible? (i.e., collection agency? Hospital?) After what period of time? (in days)	**Hospital**	**Collection Agency**	**Both**	
	18	25	3	
When an account is determined to be uncollectible, how does the hospital classify the account? (e.g., bad debt?)	**Bad Debt**	**Charity**		
	45	1		
Who determines whether or not a patient has assets available to satisfy outstanding debt? (i.e., collection agency? Hospital?)	**Hospital**	**Collection Agency**	**Both**	
	13	24	14	
Is your collection agency authorized to pursue legal judgments? (e.g., garnishment of wages, Lien on assets - undertaken by hospital? Collection agency?)	**No answer**	**Yes**	**No**	
	3	22	21	
Does your hospital charge interest for accounts in bad debt collections? (Detail including rates and terms provided within individual hospital survey responses).	**Yes**	**No**		
	11	34		
In what circumstances will the hospital execute a legal judgment? (Examples provided within individual hospital survey responses).	**Qualitative response – Please see individual hospital survey responses**			
If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's external collection policy different (yes/no)? (If yes, explanations provided within individual hospital survey responses).	**No Answer**	**Yes**	**No**	
	1	8	36	
Other Credit and Collection Information				
Does your hospital expend funds to enroll patients eligible for insurance coverage in such programs? (Names of programs/products and amount spent, if provided, included in individual hospital survey responses).	**Yes**	**No**	**Total Amount Spent**	**Average Amount Spent**
	37	9	$9,082,968	$201,844
What percentage of cases get turned over to a bad debt collection agency? Please use the following formula to calculate: **# of cases to bad debt collections/total number of cases**	**Average % of cases sent to bad debt**			
	17.51%[24]			
What percentage of cases go to legal action? Please use the following formula to calculate: **# of cases to legal action/total number of cases**	**# of Hospitals less than 1%**	**Average % of cases referred to legal action**		
	9	5.03%[25]		

[24] N=37 hospitals. Remaining hospitals replied in terms of % of revenue.

[25] N=31 hospitals. Remaining hospitals replied in terms of % of revenue.

HSCRC Survey on Credit and Collection Practices of Maryland Hospitals - 2009

Below are the list of questions that hospitals were asked as part of the HSCRC's informal hospital credit and collection survey. More detailed answers to survey questions can be found within the individual hospital survey responses, which are included as an attachment to this report.

Survey Question	Response[26]			
A. Internal Hospital Collection Policy				
If a patient gives no response to the hospital's collection efforts, when does the hospital refer the account to a collection agency (in days)?	**45-59**	**60-89**	**90-119**	**120+**
	1	8	25	9
If a patient agrees to a reasonable collection plan with the hospital, does this stop the timing cycle for referring a patient's account to a collection agency?	**Yes**		**No**	
	41		2	
Does your hospital charge interest for payment plans for accounts in active AR? (Hospital rates and terms can be found within an individual hospital's response)	**Yes**		**No**	
	0		43	
Does your hospital bill include the following or a similar statement? "This bill is only for hospital services. You should expect a separate bill from your physician."	**Yes**		**No**	
	39		4	
Do you have a single phone number on the hospital bill that a patient can call to get their questions answered?	**Yes**		**No**	
	42		1	
If a patient has a history of previous non-payment, is the credit and collection process different? (e.g., immediate write-off to bad debt, commence full billing cycle?)	**Yes**		**No**	
	11		32	
If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's internal collection policy different (yes/no)? (Detailed explanations can be found in an individual hospital's response)	**Yes**		**No**	**N/A**
	16		26	1
B. External Hospital Collection Policy				
How is the account classified once it moves to a collection agency? (e.g., bad debt?)	**Bad Debt**		**Accounts Receivable**	
	43		0	
While a debt is at a collection agency, is the debt permitted to be noted on a patient's credit report? If yes, please provide details (when noted on credit report, how long, etc.).	**Yes**		**No**	
	32		11	
Who determines when an account should be considered uncollectible? (i.e., collection agency? Hospital?) After what period of time? (in days)	**Hospital**	**Collection Agency**	**Both**	
	14	13	16	
When an account is determined to be uncollectible, how does the hospital classify the account? (e.g., bad debt?)	**Bad Debt**	**Charity**	**Both/Either**	
	42	0	1	
Who determines whether or not a patient has assets available to satisfy outstanding debt? (i.e., collection agency? Hospital?)	**Hospital**	**Collection Agency**	**Both**	
	4	17	23	
Is your collection agency authorized to pursue	**No answer**	**Yes**	**No**	

[26] N=43 responses, or 47 hospitals. Easton Memorial and Dorchester replied as one system response, Shady Grove and Washington Adventist replied as one system response, Prince Georges and Laurel Regional replied as one system response, and University of Maryland and Kernan replied as one system response. Additionally, 46 respondents are not-for-profit, and one is for-profit.

legal judgments? (e.g., garnishment of wages, Lien on assets - undertaken by hospital? Collection agency?)	0	30	13

Does your hospital charge interest for accounts in bad debt collections? (Detail including rates and terms provided within individual hospital survey responses).	**Yes**	**No**
	7	36
In what circumstances will the hospital execute a legal judgment? (Examples provided within individual hospital survey responses).	**Qualitative response – Please see individual hospital survey responses**	

If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's external collection policy different (yes/no)? (If yes, explanations provided within individual hospital survey responses).	**No Answer**	**Yes**	**No**
	1	8	33

C. Other Credit and Collection Information

Does your hospital expend funds to enroll patients eligible for insurance coverage in such programs? (Names of programs/products and amount spent, if provided, included in individual hospital survey responses).	**Yes**	**No**	**Total Amount Spent**	**Average Amount Spent**
	37	6	$12,262,764.13	$285,180.56

What percentage of cases get turned over to a bad debt collection agency? Please use the following formula to calculate: **# of cases to bad debt collections/total number of cases**	**Average % of cases sent to bad debt**
	13.04%

What percentage of cases proceed to legal action? Please use the following formula to calculate: **# of cases to legal action/total number of cases**	**# of Hospitals less than 1%**	**Average % of cases referred to legal action**
	33	1.97%

Appendix IV – Description of Focused Special Audit Process- FY 2009

SPECIAL AUDIT PROCEDURES - FINANCIAL ASSISTANCE, CREDIT & COLLECTION POLICIES AND HANDLING OF RECOVERIES

Financial Assistance

1. Hospitals are required by regulation to post notices in conspicuous places throughout the hospital describing their financial assistance policy and how to apply for free and reduced care.

- Determine whether such notices are posted.
- Describe the content of the notices and list where they are posted in the hospital.
- Determine by inquiry of the appropriate hospital personnel if patients are informed of the availability of financial assistance in any way other than by the posted notices.

2. Review the hospital=s Financial Assistance Policy (provided by the HSCRC). Select a representative sample of 50 cases, from the period September 1st through December 31st 2008, of patients who have applied for financial assistance. The sample shall include inpatient and outpatient cases and shall include both patients approved for financial assistance and those who were denied.

Determine whether the Financial Assistance Policy was followed:

1. Provide the number of cases and percentage of sample in which the policy was followed 100%;

2. Provide the number and percentage of cases in which the policy was not followed;

3. When the policy was not followed, provide examples of deviation from the policy and their frequency.

Credit and Collection Policy

1. Review the hospital=s Credit & Collection Policy (provided by the HSCRC). Select a representative sample of 50 cases that have required collection effort within the last twelve months. The sample shall include both inpatient and outpatient cases and shall include cases from insured as well as self-pay patients, as well as patients who have been granted partial financial assistance, if applicable.

Determine whether the Credit and Collection Policy was followed:
1. Provide the number of cases and the percentage of the sample in which the policy was followed 100%;

2. Provide the number and percentage of cases in which the policy was not followed;

3. When the policy was not followed, provide examples of deviation from the policy and their frequency.

Determine, from examination of primary and secondary payers, the number and percentage of cases in which a patient has been granted Medicaid eligibility and in which credit and collection activity was nevertheless applied.

Recoveries

1. Select a representative sample of 50 cases from the period September 1st through December 31st 2008 where recoveries of bad debts were made (add cases from most recent calendar quarters to reach sample if necessary):

Determine if the hospital=s uncompensated care for the year of recovery was reduced by the full amounts recovered and that the recovered amount is not reduced by collection agency fees or other collection expenses:

1. Provide the number of cases and the percentage of the sample in which any part of the recovery was applied to the hospital=s bad debt expense or reserve;

2. Of the cases where all or part of the recovery was applied to the hospital=s bad debt expense or reserve:

a) Provide the number of cases and percentage of the sample in which the gross amount of the bill recovered was applied to the hospital=s bad debt expense or reserve; and

b) Provide the number of cases and percentage of the sample in which the gross amount of the bill recovered was not applied to the hospital=s bad debt expense or reserve.

Appendix V – Analysis of UC Funding by Hospital 1998-2007

UC in Rates vs. Actual UC (% of Gross Charges)

Hospital Name	FY 1998 UC in Rates less Actual UC	FY 1999 UC in Rates less Actual UC	FY 2000 UC in Rates less Actual UC	FY 2001 UC in Rates less Actual UC	FY 2002 UC in Rates less Actual UC	FY 2003 UC in Rates less Actual UC	FY 2004 UC in Rates less Actual UC	FY 2005 UC in Rates less Actual UC	FY 2006 UC in Rates less Actual UC	FY 2007 UC in Rates less Actual UC	10 Year Totals
Washington County Hospital	(1,710,553)	1,149,955	2,775,153	564,485	(431,120)	293,165	(1,600,756)	(2,012,667)	(2,021,672)	(444,794)	(3,438,804)
Univ. of Maryland Medical System 1	(59,307)	(424,250)	2,087,497	(6,706,483)	(251,960)	2,470,411	24,113,558	(5,301,067)	(2,792,835)	(2,153,996)	10,981,569
Prince Georges Hospital	(2,893,055)	(5,667,033)	(6,249,839)	752,398	4,273,711	5,918,710	6,398,983	(6,456,016)	160,697	(4,278,974)	(8,040,418)
Holy Cross Hospital of Silver Spring	(334,146)	(593,132)	(1,874,452)	76,035	850,324	1,494,146	1,104,121	(3,112,350)	(1,488,607)	621,473	(3,256,588)
Frederick Memorial Hospital	156,445	(1,752,056)	(860,940)	(563,289)	212,230	(1,628,179)	1,729,788	(453,557)	458,125	(764,110)	(3,465,543)
Harford Memorial Hospital	(290,659)	(873,230)	69,633	74,859	15,520	(2,059,398)	(1,743,051)	(1,146,408)	(998,095)	(1,083,557)	(8,034,386)
St. Josephs Hospital	(853,999)	1,613,932	1,661,421	3,013,112	1,131,563	2,066,434	2,161,883	37,785	3,352,381	(1,676,094)	12,508,419
Mercy Medical Center, Inc.	(1,053,915)	(2,496,032)	(1,141,026)	1,490,086	1,935,855	3,197,536	2,959,369	(953,813)	543,534	2,057,991	6,539,585
Johns Hopkins Hospital	(2,225,655)	(941,427)	2,458,650	15,294,183	20,696,083	16,806,986	20,479,759	15,503,866	10,867,708	7,225,944	106,166,097
Dorchester General Hospital	(701,613)	(1,044,999)	(862,245)	(473,484)	375,259	(820,952)	(907,979)	176,587	(236,560)	601,142	(3,894,844)
St. Agnes Hospital 2	2,535,133	(241,204)	973,457	965,904	(226,357)	143,703	235,069	(1,462,017)	397,562	1,774,307	5,095,556
Sinai Hospital	(6,752,610)	793,472	2,055,502	(2,303,743)	(2,741,787)	2,984,981	2,948,146	(3,310,219)	(5,427,620)	(780,553)	(12,534,431)
Bon Secours Hospital	(2,298,445)	(1,455,910)	(4,592,148)	(3,017,204)	(798,464)	1,942,405	2,537,262	566,596	(2,073,340)	(2,669,423)	(11,858,672)
Franklin Square Hospital	678,393	(864,819)	2,947,537	2,839,012	1,673,898	(1,109,279)	(1,670,169)	(3,247,341)	(3,289,016)	(1,702,228)	(3,744,013)
Washington Adventist Hospital 3	(4,626,297)	(1,626,179)	(4,693,688)	3,383,468	81,825	535,815	1,792,508	(652,024)	(3,179,061)	(5,296,959)	(14,280,593)
Garrett County Memorial Hospital	382,075	348,174	194,042	136,407	349,288	126,393	450,900	(63,789)	(229,172)	166,917	1,861,234
Montgomery General Hospital	353,835	365,602	13,074	(746,962)	(454,098)	(344,878)	(299,587)	(221,188)	(1,126,218)	802,165	(1,658,254)
Peninsula Regional Medical Center	(439,125)	889,945	1,792,765	2,338,994	1,696,186	2,337,678	2,038,463	1,058,979	(2,047,820)	(159,580)	9,506,486
Suburban Hospital Association,Inc	1,282,811	2,613	273,463	1,820,745	(1,486,769)	902,324	1,876,459	1,955,011	253,539	774,037	7,654,233
Anne Arundel General Hospital	871,647	1,208,269	1,364,063	1,015,209	(191,570)	943,344	1,427,006	2,273,252	(1,137,575)	1,963,865	9,737,510
Union Memorial Hospital	(1,950,615)	(3,785,704)	1,406,108	(31,635)	1,116,495	3,594,574	969,119	(4,682,211)	(1,448,948)	723,430	(4,089,387)
The Memorial Hospital	308,033	(913,830)	(610,056)	(698,601)	(212,749)	102,597	227,030	505,166	664,316	(339,614)	(967,708)
Sacred Heart Hospital	433,938	1,076,553	1,227,771	(87,979)	303,593	1,052,822	600,817	2,039,587	624,333	(530,837)	6,740,597
St. Marys Hospital	1,266,920	1,503,228	1,365,695	51,181	645,004	239,763	(204,043)	299,276	1,230,166	648,453	7,045,643
Johns Hopkins Bayview Med. Center	978,155	507,000	1,580,931	(1,210,967)	17,236	3,816,176	3,459,820	(4,761,777)	202,634	1,014,716	5,603,925
Kent & Queen Annes Hospital	(327,263)	(601,647)	465,385	(397,427)	(18,731)	(966,818)	(768,481)	(1,401,842)	(810,899)	(2,871,682)	(7,699,405)
Union Hospital of Cecil County	(497,994)	(191,862)	526,615	923,696	409,762	83,986	105,047	847,803	(992,626)	752,188	1,966,615
Carroll County General Hospital	(128,795)	(791,949)	(668,605)	899,064	1,808,192	335,166	(515,657)	(517,749)	1,853,218	1,304,559	3,577,444
Harbor Hospital Center	(1,834,826)	(1,524,390)	1,785,724	(751,047)	1,026,943	729,434	100,389	(2,794,204)	(1,814,500)	218,693	(4,857,784)
Civista Medical Center	149,759	(2,176,658)	(349,626)	274,454	1,817,067	234,475	889,950	(239,545)	1,001,951	1,663,711	3,265,538
Memorial Hospital at Easton	214,454	(825,575)	(2,147,711)	(636,499)	972,530	(312,746)	154,859	(2,215,059)	1,153,573	3,004,271	(637,903)
Maryland General Hospital	641,149	(1,313,145)	786,532	1,760,648	2,182,298	2,044,814	3,248,470	(734,026)	(3,546,418)	(797,886)	4,272,436
Calvert Memorial Hospital	(116,720)	151,225	659,247	609,892	141,138	(727,860)	161,281	360,365	353,769	502,014	2,094,351
Northwest Hospital Center, Inc.	(203,444)	413,481	(851,588)	(2,144,200)	(255,607)	(1,979,141)	(1,184,939)	(1,737,668)	(2,932,157)	(412,742)	(11,288,003)
North Arundel General Hospital	(2,051,980)	(54,276)	989,097	(631,987)	255,497	(1,571,298)	(100,682)	(145,111)	(1,160,669)	(2,823,987)	(7,295,396)
Greater Baltimore Medical Center	(1,124,720)	901,738	(2,188,265)	(1,193,801)	(291,534)	(1,126,734)	(1,255,164)	(2,253,209)	2,310,959	3,128,617	(3,092,112)
McCready Foundation, Inc.	(550,377)	(202,256)	(266,465)	(494,051)	(874,216)	(436,194)	(27,259)	(216,076)	98,452	18,270	(2,950,172)
Howard County General Hospital	(877,257)	178,519	(262,647)	129,630	(618,835)	300,027	832,448	(1,993,117)	148,503	1,426,922	(735,806)
Upper Chesepeake Medical Center	231,112	377,324	19,283	(453,576)	(1,294,960)	(611,176)	(1,178,484)	565,403	1,666,673	(203,223)	(881,624)
Doctors Community Hospital	497,995	603,098	7,647,618	1,876,295	1,513,354	(564,195)	(860,640)	(2,222,331)	(1,901,787)	(2,631,933)	3,957,474
Southern Maryland Hospital	1,299,592	729,673	868,322	891,837	1,131,154	672,507	(614,160)	(236,349)	(3,220,566)	(3,464,915)	(1,942,906)
Laurel Regional Hospital	(907,487)	(825,485)	(2,611,393)	(822,916)	1,180,027	(1,535,817)	(1,871,955)	(6,022,044)	(1,576,922)	(672,081)	(15,666,072)
Good Samaritan Hospital	(907,424)	(2,422,566)	(2,032,826)	(796,861)	(191,910)	(233,806)	(3,174,301)	(6,578,970)	(162,313)	2,879,084	(13,621,894)
Shady Grove Adventist Hospital	(3,997,726)	(1,754,695)	(2,301,965)	3,221,377	2,864,468	(539,920)	845,266	(1,637,735)	(3,070,873)	(829,155)	(7,200,959)
James Lawrence Kernan Hospital	(173,332)	(455,263)	(735,035)	(673,317)	(1,852,779)	(483,021)	(442,613)	764,757	1,193,258	(88,726)	(2,946,070)
Fort Washington Medical Center	(82,558)	(529,258)	(779,572)	78,430	(694,466)	(1,193,586)	(1,015,523)	(62,994)	(1,944,061)	(960,284)	(7,183,873)
Atlantic General Hospital	22,397	323,426	765,098	257,602	(711,136)	(202,483)	(180,532)	(435,864)	(209,270)	320,383	(50,378)
University (MIEMSS)	(5,740,906)	(1,874,481)	(4,367,728)	(5,315,456)	(1,023,920)	3,609,740	7,911,348	9,078,626	5,109,642	(2,337,216)	5,049,649
University (UMCC)	(613,674)	(354,075)	(38,226)	(581,392)	1,491,523	2,279,452	4,753,547	5,908,965	3,281,883	(238,322)	15,889,682
Total All Hospitals	(34,022,635)	(25,440,158)	(1,726,361)	14,006,126	37,545,059	42,812,083	76,896,691	(27,338,312)	(13,912,724)	(6,619,723)	62,200,046

Source: HSCSC Annual File 1998-2007

Appendix VI – Analysis of Charity Care as a percentage of Actual UC 1998-2007

Charity Care as a Percentage of Actual UC
By Hospital
FY 1998-2007

Pct CC of total UC	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Washington Co.	39.3%	36.2%	47.8%	41.1%	34.0%	33.8%	34.8%	32.0%	33.0%	36.0%
University MD Hospital	35.2%	36.8%	44.6%	44.1%	45.3%	49.5%	52.7%	32.7%	29.2%	36.0%
Prince Georges Hospital	48.5%	34.4%	9.9%	6.0%	3.0%	3.2%	2.1%	1.0%	1.7%	1.5%
Holy Cross	43.4%	49.1%	30.7%	45.1%	45.8%	41.7%	40.3%	43.5%	31.0%	32.2%
Frederick Memorial	16.6%	10.4%	12.9%	12.4%	22.5%	24.9%	34.6%	26.7%	22.8%	21.1%
Harford Memorial	16.8%	13.1%	16.2%	16.7%	8.1%	5.6%	19.0%	11.4%	14.8%	14.1%
St Joseph Medical Ct.	46.1%	41.9%	31.0%	22.2%	13.9%	14.0%	22.0%	22.2%	29.1%	24.1%
Mercy Medical Ct.	62.8%	52.3%	51.5%	48.7%	47.6%	58.3%	22.6%	22.7%	30.0%	28.2%
Johns Hopkins Hospital	37.9%	31.7%	33.1%	29.4%	33.4%	36.5%	40.7%	35.5%	34.6%	35.1%
Dochester General	26.0%	32.0%	24.5%	27.6%	32.0%	44.3%	34.1%	34.1%	33.5%	33.1%
Saint Agnes	42.3%	30.8%	36.0%	35.9%	34.0%	34.0%	35.4%	41.8%	49.3%	54.5%
Sinai Hosp.	25.1%	31.0%	50.3%	31.2%	21.4%	38.0%	39.9%	39.3%	27.7%	27.2%
Bon Secour	50.9%	50.9%	44.3%	54.2%	58.1%	63.3%	61.6%	59.7%	45.9%	50.3%
Franklin Square.	31.1%	17.0%	19.3%	22.2%	17.0%	17.7%	19.5%	16.1%	21.3%	23.7%
Wash.Adventist	21.3%	24.0%	20.4%	10.9%	30.2%	18.8%	20.1%	22.5%	31.3%	43.1%
Garrett	74.9%	36.9%	36.1%	41.5%	45.9%	36.1%	29.5%	36.6%	33.2%	47.3%
Montgomery Gen.	58.6%	56.3%	54.5%	48.2%	43.6%	54.4%	58.4%	58.5%	65.9%	50.3%
Penisula Regional Hosp.	27.1%	20.0%	24.5%	17.7%	16.8%	15.9%	19.5%	27.7%	29.8%	29.7%
Suburban	19.5%	11.9%	15.6%	22.9%	14.2%	19.5%	26.1%	26.8%	25.8%	21.8%
Anne Arundel	17.7%	15.7%	14.2%	13.1%	14.8%	18.4%	17.2%	20.3%	19.3%	20.9%
Union Memorial	17.5%	19.1%	23.0%	26.2%	21.9%	23.1%	21.7%	20.0%	27.8%	28.0%
Memorial Cumberland	54.7%	67.2%	71.5%	62.1%	46.3%	43.5%	50.1%	64.8%	54.4%	43.0%
Sacred Heart	63.1%	58.4%	72.7%	47.5%	52.2%	49.2%	51.6%	59.4%	52.8%	47.4%
Saint Marys	24.7%	49.6%	39.9%	24.3%	32.5%	28.3%	20.9%	19.4%	23.4%	47.1%
Johns Hopkins Bayview	50.5%	49.5%	46.2%	41.8%	41.7%	45.8%	42.5%	43.4%	40.4%	44.7%
Kent & Queen Annes	6.0%	8.6%	11.6%	6.7%	3.6%	4.2%	13.4%	0.5%	0.0%	17.8%
Union of Cecil County	46.5%	30.1%	16.9%	5.0%	5.8%	5.7%	1.8%	7.0%	9.3%	16.1%
Carroll County Hospital	19.1%	10.9%	4.8%	4.2%	20.3%	12.3%	8.1%	2.9%	8.8%	42.2%
Harbor Hospital Center	38.6%	17.8%	18.9%	17.9%	10.7%	15.3%	12.8%	15.5%	25.1%	20.9%
Civista Medical Ctr	17.3%	2.1%	2.9%	4.1%	18.2%	5.5%	12.1%	16.1%	15.0%	18.8%
Memorial at Easton	34.0%	24.6%	19.7%	19.5%	27.4%	32.9%	26.5%	15.7%	32.3%	20.8%
Maryland General	9.6%	4.9%	8.6%	5.8%	8.7%	8.7%	6.8%	5.9%	5.0%	4.6%
Calvert County Hospital	34.7%	36.6%	34.8%	32.7%	32.1%	21.9%	20.5%	27.7%	26.9%	19.6%
Northwest	15.9%	21.1%	16.5%	10.0%	14.3%	10.8%	19.3%	23.7%	19.7%	22.2%
North Arundel	19.1%	16.4%	16.6%	14.9%	19.1%	19.7%	31.1%	32.6%	29.8%	14.8%
G.B.M.C	14.9%	19.2%	15.7%	15.2%	17.4%	13.1%	10.5%	11.2%	14.2%	11.0%
McCready	11.1%	22.6%	11.3%	7.4%	10.0%	9.8%	8.5%	15.3%	35.9%	32.0%
Howard County General	5.5%	9.0%	5.9%	8.7%	9.5%	9.9%	7.9%	6.1%	8.3%	9.2%
Upper Chesapeake Med.	30.9%	21.7%	13.0%	23.0%	10.2%	7.0%	9.0%	11.2%	16.6%	16.2%
Doctors Community Hos	14.7%	23.2%	10.1%	10.0%	10.1%	9.5%	6.7%	9.7%	11.0%	3.3%
Southern Maryland Hosp	8.0%	9.2%	5.1%	2.1%	10.6%	9.0%	3.8%	3.9%	4.5%	5.3%
Laurel Regional Hospital	3.1%	2.2%	1.0%	0.0%	0.6%	0.2%	0.6%	0.2%	0.4%	0.8%
Good Samaritan	26.9%	35.4%	33.4%	28.4%	17.7%	18.2%	15.4%	15.5%	18.7%	17.0%
Shady Grove	22.3%	26.8%	25.8%	9.3%	20.6%	16.4%	17.8%	21.3%	20.4%	35.6%
Kernan	0.8%	0.9%	0.0%	0.0%	0.0%	6.0%	2.5%	6.7%	9.1%	7.4%
Ft. Washington	13.5%	0.0%	4.3%	13.8%	5.1%	3.5%	20.2%	4.9%	6.5%	12.9%
Atlantic Gen.	4.2%	5.1%	9.3%	5.4%	8.6%	7.8%	4.2%	15.8%	13.9%	19.4%
University MIEMSS	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.5%	29.0%	27.2%	14.3%
University UMCC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.3%	77.8%	37.9%	28.8%
All Acute Hospitals	30.5%	27.6%	27.4%	25.1%	25.5%	26.6%	27.5%	26.0%	26.3%	26.9%

Charity Care as a Percentage of Actual UC
By Health Care System & Faith-based & AMC
FY 1998-2007

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total CC Pct of Total UC										
University MD Hospital	35.16%	36.81%	44.57%	44.09%	45.29%	49.53%	52.66%	32.67%	29.18%	36.02%
University MIEMSS	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.55%	29.01%	27.23%	14.26%
University UMCC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	60.33%	77.80%	37.92%	28.81%
Dochester General	25.99%	31.95%	24.45%	27.64%	32.02%	44.33%	34.12%	34.06%	33.49%	33.05%
Memorial at Easton	33.96%	24.62%	19.69%	19.47%	27.36%	32.94%	26.48%	15.66%	32.28%	20.79%
Maryland General	9.62%	4.90%	8.64%	5.82%	8.75%	8.70%	6.84%	5.89%	4.98%	4.57%
University MD	26.72%	25.81%	32.10%	31.04%	34.85%	39.42%	54.57%	39.81%	35.15%	33.57%
Johns Hopkins Hospital	37.87%	31.72%	33.12%	29.36%	33.38%	36.53%	40.72%	35.47%	34.58%	35.12%
Johns Hopkins Bayview	50.50%	49.51%	46.25%	41.80%	41.67%	45.77%	42.54%	43.40%	40.37%	44.71%
Howard County General	5.46%	9.04%	5.88%	8.74%	9.46%	9.87%	7.88%	6.07%	8.32%	9.20%
Hopkins	39.11%	35.23%	35.13%	32.26%	34.70%	37.75%	39.29%	35.75%	34.61%	36.25%
Prince Georges Hospital	48.54%	34.40%	9.88%	6.02%	2.95%	3.16%	2.06%	1.01%	1.65%	1.52%
Laurel Regional Hospital	3.15%	2.16%	0.99%	0.02%	0.56%	0.18%	0.56%	0.17%	0.41%	0.82%
Dimensions	40.08%	29.10%	8.02%	4.91%	2.51%	2.57%	1.76%	0.80%	1.38%	1.38%
Upper Chesapeake Med.	30.87%	21.70%	13.00%	22.98%	10.16%	6.97%	9.05%	11.21%	16.59%	16.15%
Harford Memorial	16.80%	13.14%	16.17%	16.69%	8.09%	5.59%	18.95%	11.45%	14.80%	14.10%
Upper Ches	22.31%	15.77%	14.73%	20.01%	9.31%	6.28%	13.50%	11.31%	15.77%	15.24%
Good Samaritan	26.94%	35.38%	33.36%	28.42%	17.70%	18.18%	15.39%	15.55%	18.71%	17.02%
Franklin Square.	31.10%	16.96%	19.29%	22.16%	16.99%	17.74%	19.48%	16.14%	21.26%	23.71%
Union Memorial	17.45%	19.14%	23.03%	26.18%	21.95%	23.14%	21.74%	20.03%	27.83%	28.01%
Harbor Hospital Center	38.64%	17.83%	18.92%	17.91%	10.69%	15.34%	12.76%	15.53%	25.14%	20.87%
Med Star	26.59%	20.95%	23.56%	24.03%	17.91%	19.10%	18.25%	17.19%	23.48%	23.29%
Wash.Adventist	21.32%	23.96%	20.44%	10.91%	30.19%	18.82%	20.06%	22.47%	31.31%	43.08%
Shady Grove	22.35%	26.81%	25.83%	9.33%	20.60%	16.44%	17.81%	21.27%	20.44%	35.60%
Adventist	21.83%	25.29%	22.69%	10.17%	26.25%	17.66%	18.97%	21.89%	26.34%	39.59%
Sacred Heart	63.13%	58.44%	72.71%	47.49%	52.24%	49.17%	51.57%	59.43%	52.84%	47.41%
Memorial Cumberland	54.71%	67.20%	71.49%	62.09%	46.32%	43.54%	50.06%	64.84%	54.35%	43.02%
Western MD	58.90%	63.72%	71.97%	54.36%	49.38%	46.30%	50.92%	61.99%	53.45%	45.49%
Northwest	15.91%	21.12%	16.51%	10.02%	14.27%	10.75%	19.34%	23.73%	19.75%	22.22%
Sinai	25.09%	31.05%	50.29%	31.22%	21.43%	37.98%	39.91%	39.33%	27.65%	27.15%
Lifebridge	23.47%	29.37%	42.80%	26.12%	19.90%	30.84%	35.32%	35.64%	25.65%	25.95%
Holy Cross	43.37%	49.09%	30.69%	45.11%	45.79%	41.69%	40.30%	43.47%	30.95%	32.21%
St Joseph Medical Ct.	46.12%	41.93%	31.01%	22.25%	13.89%	13.95%	21.99%	22.18%	29.06%	24.12%
Mercy Medical Ct.	62.77%	52.26%	51.47%	48.74%	47.62%	58.33%	22.59%	22.74%	30.03%	28.22%
Saint Agnes	42.26%	30.79%	36.01%	35.86%	34.03%	34.03%	35.39%	41.84%	49.27%	54.49%
Bon Secour	50.89%	50.89%	44.28%	54.17%	58.05%	63.29%	61.61%	59.72%	45.87%	50.30%
Wash.Adventist	21.32%	23.96%	20.44%	10.91%	30.19%	18.82%	20.06%	22.47%	31.31%	43.08%
Sacred Heart	63.13%	58.44%	72.71%	47.49%	52.24%	49.17%	51.57%	59.43%	52.84%	47.41%
Shady Grove	22.35%	26.81%	25.83%	9.33%	20.60%	16.44%	17.81%	21.27%	20.44%	35.60%
Faith-based	40.61%	39.31%	35.27%	37.30%	39.35%	37.55%	31.76%	33.31%	34.79%	39.05%
Non Faith Based	28.30%	25.35%	25.67%	22.94%	22.77%	24.42%	26.61%	24.47%	24.63%	24.44%
University MD Hospital	35.16%	36.81%	44.57%	44.09%	45.29%	49.53%	52.66%	32.67%	29.18%	36.02%
University MIEMSS	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.55%	29.01%	27.23%	14.26%
University UMCC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	60.33%	77.80%	37.92%	28.81%
Johns Hopkins Hospital	37.87%	31.72%	33.12%	29.36%	33.38%	36.53%	40.72%	35.47%	34.58%	35.12%
Johns Hopkins Bayview	50.50%	49.51%	46.25%	41.80%	41.67%	45.77%	42.54%	43.40%	40.37%	44.71%
AMC	31.88%	29.69%	31.69%	29.48%	31.86%	34.72%	41.00%	35.65%	32.84%	33.27%
Non-Academic	29.75%	26.55%	25.10%	22.69%	22.11%	22.75%	22.00%	21.87%	23.38%	24.13%
Overall State	30.46%	27.63%	27.42%	25.12%	25.52%	26.62%	27.50%	25.99%	26.34%	26.95%

Charity Care as a Percentage of Actual UC
By Geography
FY 1998-2007

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Urban										
University MD Hospital	35.16%	36.81%	44.57%	44.09%	45.29%	49.53%	52.66%	32.67%	29.18%	36.02%
Prince Georges Hospital	48.54%	34.40%	9.88%	6.02%	2.95%	3.16%	2.06%	1.01%	1.65%	1.52%
Mercy Medical Ct.	62.77%	52.26%	51.47%	48.74%	47.62%	58.33%	22.59%	22.74%	30.03%	28.22%
Johns Hopkins Hospital	37.87%	31.72%	33.12%	29.36%	33.38%	36.53%	40.72%	35.47%	34.58%	35.12%
Saint Agnes	42.26%	30.79%	36.01%	35.86%	34.03%	34.03%	35.39%	41.84%	49.27%	54.49%
Sinai Hosp.	25.09%	31.05%	50.29%	31.22%	21.43%	37.98%	39.91%	39.33%	27.65%	27.15%
Bon Secour	50.89%	50.89%	44.28%	54.17%	58.05%	63.29%	61.61%	59.72%	45.87%	50.30%
Wash.Adventist	21.32%	23.96%	20.44%	10.91%	30.19%	18.82%	20.06%	22.47%	31.31%	43.08%
Union Memorial	17.45%	19.14%	23.03%	26.18%	21.95%	23.14%	21.74%	20.03%	27.83%	28.01%
Johns Hopkins Bayview	50.50%	49.51%	46.25%	41.80%	41.67%	45.77%	42.54%	43.40%	40.37%	44.71%
Harbor Hospital Center	38.64%	17.83%	18.92%	17.91%	10.69%	15.34%	12.76%	15.53%	25.14%	20.87%
Maryland General	9.62%	4.90%	8.64%	5.82%	8.75%	8.70%	6.84%	5.89%	4.98%	4.57%
Good Samaritan	26.94%	35.38%	33.36%	28.42%	17.70%	18.18%	15.39%	15.55%	18.71%	17.02%
University MIEMSS	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.55%	29.01%	27.23%	14.26%
University UMCC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	60.33%	77.80%	37.92%	28.81%
Kernan	0.82%	0.93%	0.00%	0.00%	0.00%	5.95%	2.47%	6.73%	9.09%	7.39%
Total Urban	33.03%	29.82%	30.70%	27.92%	28.23%	31.23%	31.51%	28.83%	28.83%	29.48%
Suburban										
Holy Cross	43.37%	49.09%	30.69%	45.11%	45.79%	41.69%	40.30%	43.47%	30.95%	32.21%
Frederick Memorial	16.63%	10.42%	12.88%	12.36%	22.50%	24.86%	34.61%	26.74%	22.77%	21.07%
St Joseph Medical Ct.	46.12%	41.93%	31.01%	22.25%	13.89%	13.95%	21.99%	22.18%	29.06%	24.12%
Franklin Square.	31.10%	16.96%	19.29%	22.16%	16.99%	17.74%	19.48%	16.14%	21.26%	23.71%
Montgomery Gen.	58.55%	56.31%	54.54%	48.22%	43.61%	54.38%	58.37%	58.50%	65.86%	50.34%
Penisula Regional Hosp.	27.10%	19.96%	24.50%	17.74%	16.76%	15.93%	19.53%	27.66%	29.81%	29.70%
Suburban	19.50%	11.90%	15.60%	22.90%	14.22%	19.46%	26.09%	26.84%	25.77%	21.84%
Anne Arundel	17.70%	15.74%	14.16%	13.15%	14.80%	18.39%	17.23%	20.34%	19.34%	20.86%
Union of Cecil County	46.45%	30.13%	16.89%	4.95%	5.80%	5.73%	1.84%	7.05%	9.27%	16.07%
Carroll County Hospital	19.06%	10.93%	4.81%	4.24%	20.28%	12.26%	8.05%	2.93%	8.78%	42.17%
Civista Medical Ctr	17.28%	2.10%	2.94%	4.12%	18.23%	5.51%	12.05%	16.08%	14.96%	18.80%
Calvert County Hospital	34.71%	36.59%	34.84%	32.66%	32.11%	21.91%	20.53%	27.72%	26.92%	19.60%
Northwest	15.91%	21.12%	16.51%	10.02%	14.27%	10.75%	19.34%	23.73%	19.75%	22.22%
North Arundel	19.05%	16.40%	16.60%	14.93%	19.06%	19.66%	31.06%	32.57%	29.76%	14.81%
G.B.M.C	14.93%	19.19%	15.70%	15.16%	17.41%	13.07%	10.46%	11.18%	14.15%	11.05%
Howard County General	5.46%	9.04%	5.88%	8.74%	9.46%	9.87%	7.88%	6.07%	8.32%	9.20%
Upper Chesapeake Med.	30.87%	21.70%	13.00%	22.98%	10.16%	6.97%	9.05%	11.21%	16.59%	16.15%
Doctors Community Hos	14.70%	23.16%	10.08%	10.00%	10.09%	9.49%	6.74%	9.73%	10.99%	3.34%
Southern Maryland Hosp	8.03%	9.21%	5.05%	2.06%	10.61%	9.04%	3.79%	3.87%	4.51%	5.34%
Laurel Regional Hospital	3.15%	2.16%	0.99%	0.02%	0.56%	0.18%	0.56%	0.17%	0.41%	0.82%
Shady Grove	22.35%	26.81%	25.83%	9.33%	20.60%	16.44%	17.81%	21.27%	20.44%	35.60%
Ft. Washington	13.46%	0.00%	4.31%	13.81%	5.11%	3.54%	20.21%	4.93%	6.53%	12.88%
Atlantic Gen.	4.21%	5.11%	9.26%	5.38%	8.64%	7.77%	4.18%	15.80%	13.94%	19.42%
Total Suburban	23.75%	20.93%	18.01%	17.03%	18.22%	17.19%	19.08%	20.24%	20.77%	21.10%
Rurual										
Washington Co.	39.31%	36.21%	47.78%	41.15%	34.03%	33.76%	34.85%	32.01%	33.05%	36.02%
Dochester General	25.99%	31.95%	24.45%	27.64%	32.02%	44.33%	34.12%	34.06%	33.49%	33.05%
Garrett	74.95%	36.93%	36.09%	41.53%	45.92%	36.08%	29.55%	36.59%	33.22%	47.35%
Memorial Cumberland	54.71%	67.20%	71.49%	62.09%	46.32%	43.54%	50.06%	64.84%	54.35%	43.02%
Sacred Heart	63.13%	58.44%	72.71%	47.49%	52.24%	49.17%	51.57%	59.43%	52.84%	47.41%
Saint Marys	24.67%	49.57%	39.86%	24.33%	32.55%	28.25%	20.88%	19.42%	23.42%	47.05%
Kent & Queen Annes	5.95%	8.56%	11.56%	6.74%	3.58%	4.18%	13.37%	0.49%	0.00%	17.81%
Memorial at Easton	33.96%	24.62%	19.69%	19.47%	27.36%	32.94%	26.48%	15.66%	32.28%	20.79%
McCready	11.06%	22.62%	11.26%	7.43%	10.04%	9.83%	8.53%	15.27%	35.91%	31.98%
Total Rural	38.97%	38.07%	39.25%	33.69%	34.08%	33.39%	33.16%	29.66%	33.24%	35.84%

Source: HSCRC Annual Filing 1998-2007

Appendix VII – Summary of Other State Legislation

Summary of California Assembly Bill No. 774, Chapter 755
September 29, 2006

1. Requires each hospital, as a condition of licensure, to maintain written policies about discount payment and charity care for financially qualified patients:
    a. Addresses eligibility criteria
        i. Uninsured patients
        ii. Patients with high medical costs who are at or below 350% of FPL
        iii. Hospital may choose to grant eligibility to patients with income levels over 350%
        iv. Clearly states eligibility criteria based upon income
        v. Allows for extended payment plan, and provision that hospital and patient may negotiate the terms of the payment plan
        vi. Patient may seek review of determination to appropriate individual designated in the policy
        vii. Income and monetary assets(with exception of retirement or deferred compensation plans) may be considered:
            1. Except retirement or deferred compensation plans
            2. First $10,000 of patient's monetary assets should not be counted, nor shall 50% of a patient's monetary assets over the first $10,000 be counted in determining eligibility.
    b. Addresses patient responsibility in providing documentation of income and health benefits coverage. If a patient fails to provide documentation, hospital may consider that failure in making determination.
    c. Eligibility may be determined at any time hospital receives information.
    d. Provides patients with notice about the hospital's discount payment and charity care policies, including information about eligibility for private or public health insurance coverage.
        i. Includes contact information for hospital employee or office
        ii. Should also be provided to patients seeking emergency and outpatient care
        iii. Shall be provided in applicable languages
        iv. Notice posted in locations visible to the public
    e. Hospital should make reasonable efforts to obtain from patient about sponsorship to fully or partially cover charges: private health insurance, Medicare, Medi-Cal (Medicaid) program, etc.
    f. Specifies billing and collection procedures to be followed by a hospital or its assignees, collection agencies, or billing service.
        i. Statements should include charges for services rendered by the hospital
        ii. Request patient inform the hospital if patient has third party sponsorship
        iii. Statement that if consumer does not have coverage, the consumer may be eligible for government sponsored programs or charity care

iv. Statement detailing how patients may obtain applications. Application should be provided prior to discharge if the patient has been admitted, or to patients receiving emergency or outpatient care.
v. Statement that if patient meets income requirements, patient may qualify for discounted payment or charity care.
vi. Each hospital shall establish written policy defining standards for the collection of debt, and obtain written agreement from any agency that it will adhere to the hospital's policies.
vii. For a patient who lacks coverage, or for a patient that provides information that he may incur high medical costs, a hospital shall not report adverse information to consumer credit reporting agency or commence civil action for nonpayment prior to 150 days after initial billing.
viii. Extended payment plans should be interest free.
ix. Prior to commencing activities against a patient, the hospital or other owner of the debt, including collection agency, shall provide patient with clear conspicuous written notice of:
    1. Patient rights pursuant to Rosenthal Fair Debt Collection Practices Act
    2. Nonprofit credit counseling services may be available
    3. Indicates that commencement of collection activities may occur
x. A collection agency or other assignee that is not a subsidiary of the hospital shall not, in dealing with any patient under the hospital's charity care of discount payment policies, use any of the following:
    1. Wage garnishment, except by order of the court
    2. Notice or conduct a sale of the patient's primary residence during the life of the patient or his/her spouse
    3. Does not preclude a hospital, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy from third party liability settlements, tortfeasors, or other legally responsible parties.

g. Requires overcharges be reimbursed to patients.

2. Requires submission of policies, eligibility procedures, review process and application for charity care or discounted payment.
    a. To be provided at least biennially or when a significant change is made
3. Provides that, to the extent that certain of the bill's requirements result in a specified federal determination relating to the hospital's established charge schedule, the requirement in question shall be inoperative with respect to all general acute care hospitals.

Summary of Illinois House Bill 4999-Fair Patient Billing Act

Purpose: Advance the prompt and accurate payment of health care services through fair and reasonable billing and collection practices of hospitals.

1. Requires patient notification:
    a. Following required notice "You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information, contact (hospital financial assistance representative)."
    b. Posted conspicuously
    c. Shall be in English, and in any other language that is the primary language of at least 5% of patients served
    d. Notice shall be posted on website:
        i. Financial assistance is available
        ii. Description of financial assistance process
        iii. Copy of financial assistance application
    e. Notice shall be available in a brochure, or other written format
2. Patient statements will include
    a. Date health care services were provided
    b. Brief description of hospital services
    c. Amount owed for hospital services
    d. Hospital contact information for addressing billing inquiries
    e. Statement regarding how uninsured patient may apply for financial assistance
    f. Notice that itemized bill can be obtained upon request
3. Billing inquiries:
    a. Hospital must have a process for patients to inquire or dispute their bill
        i. Must include telephone number allowing patient to inquire or dispute their bill
        ii. May include toll free number, address to which patient may write, web-site or e-mail address, or department patient may call or write
        iii. Hospital must return calls by patients promptly, but no later than 2 business days after the call is made
        iv. Hospital must respond to correspondence from the patient within 10 business days of receipt
4. Pursuing collection action:
    a. Hospitals and their agents may pursue collection action only if following conditions are met:
        i. Hospital has given uninsured patient opportunity to assess bill for accuracy, apply for financial assistance, avail themselves to a reasonable payment plan
        ii. If uninsured has indicated inability to pay full amount in one payment, the hospital has offered a reasonable payment plan. Hospital may require uninsured patient to provide reasonable verification of inability to pay in one payment
        iii. The uninsured patient should be given at least 60 days following date of discharge to submit application for financial assistance
        iv. If uninsured patient has agreed to payment plan and patient has failed to make payments
        v. If uninsured patient has applied for health care coverage under government sponsored health care program but the patient's application is denied
    b. A hospital may not refer a bill to a collection agency without first offering a reasonable payment plan. This should be made available within 30 days following the bill date. If

patient fails to agree to a plan within 30 days of request, hospital may proceed with collection action
    c. No collection agency, law firm, may initiate legal action for non-payment of a hospital bill against a patient without written approval of authorized hospital employee
5. Collection limitations:
    a. Hospital shall not pursue legal action for non-payment against uninsured patients who have clearly demonstrated that they have neither sufficient income nor assets to meet financial obligations
6. Patient responsibilities:
    a. Patient must cooperate in good faith by providing all reasonably requested financial documentation
    b. Patient should communicate any material change in patient's financial situation
7. Notification concerning out-of-network providers should be provided during admission or as soon as practicable:
    a. Patient may receive separate bills for services provided by other health care professionals
    b. Some hospital staff members may not be participating providers in the same insurance plans and networks as the hospital
    c. Patient may have greater financial responsibility for services provided by out of network providers
    d. Questions about coverage should be directed to the patient's health care plan
8. Attorney General is responsible for administering and ensuring compliance with this act.

Summary of Illinois Hospital Uninsured Patient Discount Act SB 2380, September 23, 2008

(Provisions apply to hospitals beginning April 1, 2009)

1. Act requires all hospitals to provide discounts to uninsured patients meeting eligibility criteria:
    a. Discounts must result in bills of no more than 135% of cost. Applicable only to charges exceeding $300 in any one encounter
    b. Patients may be required to apply for Medicare, Medicaid, SCHIP or other public program if reason to believe they would qualify
    c. Patients may apply within 60 days of service
    d. Patients must provide third party verification of income, information regarding assets, and documentation of residency within 30 days of request:
        i. Copy of most recent W2 form and 1099 form
        ii. Copy of most recent tax return
        iii. Copies of the two most recent pay stubs
        iv. Written income verification from an employer if paid in cash
        v. One other reasonable form of third party income verification deemed acceptable to the hospital
    e. Residency documentation requirements:
        i. Any document listed for determination of income
        ii. Valid state issued ID
        iii. Recent residential utility bill
        iv. Lease agreement
        v. Vehicle registration card
        vi. Voter registration card
        vii. Mail addressed to uninsured from a government or other credible source
        viii. Statement from family member of uninsured who resides at same address
        ix. Letter from homeless shelter/other similar facility verifying that the uninsured resides at the facility
    f. Maximum collectible amount in a 12 month period is 25% of annual gross family income and do not have significant assets. Patient must inform hospital of prior services which were determined to be eligible
    g. Hospital may exclude patient from 25% maximum who has substantial assets (defined as a value in excess of 600% FPL urban/300% at CAH and rural areas). Certain assets are not considered: primary residence, exempt personal property, and any amounts in pension or retirement plan
    h. Applies to medically necessary health care services. Does not apply to elective cosmetic or non-medical services
    i. Patients who have high deductible health plans are not eligible
    j. Patients must be Illinois resident (Relocation to Illinois for health care benefits does not satisfy)
    k. Must have family income of no more than 600% FPL in urban areas, or 300% FPL at Critical Access Hospitals or in rural areas