

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 09 Fee Assessment for Financing Hospital Uncompensated Care

**Authority: Health-General Article, §§ 19-207; 19-207.1, 19-207.3, 19-213; and 19-214,
Annotated Code of Maryland**

.01 Definitions.

- A. In this chapter, the following terms have the meanings indicated.
- B. Terms Defined.
- (1) “Automated clearing house (ACH)”, as defined in COMAR 03.01.02.01B, means a central clearing organization that operates as a clearing house for transmitting or receiving entries between banks and bank accounts, and authorizes an electronic transfer of funds between banks or bank accounts.
- (2) “Commission” means the Health Services Cost Review Commission.
- (3) “Comptroller” means the Comptroller of the Treasury or the Comptroller’s designee.
- (4) “General Accounting Division” means the Fiscal Services Administration for the Department of Health and Mental Hygiene.
- (5) “Health Services Cost Review Commission Fund” means the special fund established under Health-General Article, § 19-207.1 (d), Annotated Code of Maryland.
- (6) “Hospital” means an institution that is licensed by the Department of Health and Mental Hygiene as an acute general hospital.
- (7) “Hospital Uncompensated Care Fund” means the monies that are collected from hospitals for the equitable financing of hospital uncompensated care and which are a discrete part of the Health Services Cost Review Commission Fund.
- (8) “Interest” means the investment earnings generated from the investment and reinvestment of the monies of the Hospital Uncompensated Care Fund which are separately held by the Treasury, accounted for by the Comptroller, and retained to the credit of the Health Services Cost Review Commission Fund.

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(9) “Mark-up” means the mechanism used to increase hospital rates to allow for payer differentials, working capital (prompt payment) differentials, and a provision for uncompensated care.

(10) “Remittance” means the amount each hospital remits to the General Accounting Division pursuant to the predetermined formula established by the Commission to provide funding for the Commission’s Hospital Uncompensated Care Fund.

(11) “Special rate adjustment” means an adjustment to a hospital’s rates, which will bring the hospital’s uncompensated care provision of its mark-up to the Statewide uncompensated care coverage.

(12) “Treasury” means the State Treasury.

(13) “Wire transfer” means an electronic transaction in which a hospital through the hospital’s bank and an automated clearing house, originates an entry crediting the Health Services Cost Review Commission Fund’s bank account and debiting the hospital’s bank account on the same day the transaction is initiated.

.02 Special Rate Adjustment and Collection.

A. The Commission shall make a special rate adjustment to the uncompensated care provision of each hospital’s mark-up to pay for the financing of the reasonable costs of hospital uncompensated care. The Commission shall notify hospitals in writing of the amount due to be remitted in a given month before the first day of that month.

B. On or before the first business day of each month, the Commission shall direct the General Accounting Division to arrange for the collection of the amount due to be remitted by individual hospitals. This amount shall be based on the difference between a hospital’s uncompensated care provision in its mark-up and the Statewide uncompensated care average.

C. The Commission shall, at the same time, notify the General Accounting Division in writing of the:

- (1) Hospitals due to remit for that month;
- (2) Amount of the remittance for that month;
- (3) Hospitals to receive payments from the Hospital Uncompensated Care Fund for that month;

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(4) Amount to be disbursed to hospitals from the Hospital Uncompensated Care Fund in that month; and

(5) The appropriate banking account information from each hospital in order to debit or disburse funds electronically by wire transfer.

D. All funds collected shall be transferred to the Hospital Uncompensated Care Fund.

.03 Payment of Remittance Due.

A. By January 1, 2009, each hospital shall provide the Commission with sufficient banking information to facilitate the collection and disbursement of funds by the ACH or other wire transfer method. Each hospital shall initiate or authorize the ACH or other wire transfer method as directed by the Commission.

B. On or before the 5th business day of each month, each hospital identified as due to remit monies in accordance with the provisions of these regulations shall make payment into the Hospital Uncompensated Care Fund in the manner prescribed by the Commission.

C. On or before the 5th business day of each month, the Comptroller shall transfer monies out of the Hospital Uncompensated Care Fund and distribute monies to hospitals in the manner prescribed by the Commission.

.04 Use of Funds.

A. Funds generated through the special rate adjustment and the remittance due may only be used to finance the delivery of hospital uncompensated care.

B. Interest earned from the monies collected shall be retained to the credit of the Hospital Uncompensated Care Fund.

C. Interest earned may be used to pay for the reasonable expenses associated with implementation of the alternative methodology approved by the Commission for financing the reasonable costs of hospital uncompensated care.

.05 Uncompensated Care Reduction Program.

A. Request for Proposals.

(1) At any time on or after April 1, 1998, the Commission may issue a request for proposals for hospital-sponsored applications that propose programs designed to reduce hospital uncompensated care.

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(2) Before issuing a request for proposals, the Commission may hold an orientation conference to inform hospitals about the structure and requirements of the Uncompensated Care Reduction Program, as it considers necessary and proper.

B. Letter of Intent Required for Reduction Program Review.

(1) A hospital that intends to apply for a grant shall first submit to the Commission a letter of intent in the form and manner required by the Commission. The nature and extent of information required in the letter of intent may vary according to the type or scope of services being proposed.

(2) The Commission staff shall review the letter of intent and consult with the Uncompensated Care Reduction Program administrator. The Commission staff shall respond in writing to each potential applicant. Upon request, the Commission staff or the Program administrator may arrange to meet with the potential applicant before the hospital undertakes the full grant application, to discuss:

(a) Commission procedures for reviewing the forthcoming application;

(b) Information and data to be included in the application; and

(c) Other matters relevant to the filing and processing of the application.

C. Application for Reduction Program Review.

(1) A hospital may apply for a maximum of one grant per calendar year.

(2) An application shall be submitted to the Commission in accordance with the schedules set forth in the request for proposals. The procedure for submitting an application under the Uncompensated Care Reduction Program shall be in the form and manner required by the Commission in its request for proposals. The Commission staff or the Program administrator shall provide technical assistance to a grant applicant hospital upon request.

(3) The staff of the Commission and the Program administrator shall review all applications for completeness. The Program administrator, the staff, or the evaluation committee may request information from the applicant supplementing the grant application at any time during the evaluation of an application.

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D. Uncompensated Care Reduction Program Evaluation Committee.

(1) The Commission shall appoint an evaluation committee consisting of seven voting members and two alternates. The specific composition of the committee shall be as follows:

- (a) Three technical representatives;
- (b) Two hospital representatives (one as an alternative);
- (c) One representative of business;
- (d) Two third-party payer representatives (one as an alternative); and
- (e) One community health representative.

(2) The evaluation committee shall have a rotating chair, and members shall serve staggered, 3-year terms.

(3) An evaluation committee member may not participate in the evaluation of a grant application if participation represents an actual or apparent conflict of interest.

E. Evaluation and Disposition of Applications.

(1) Applications shall be evaluated on the basis of:

- (a) All relevant standards, policies, and criteria established by the Commission and identified in the request for proposals; and
- (b) The application's potential to reduce hospital uncompensated care.

(2) Within 60 days from the receipt of the application, the evaluation committee shall issue the committee's grant recommendations in writing to the Commission.

(3) The Commission shall issue the Commission's decision on all grant awards at a public meeting.

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(4) All applicants shall be informed in writing of the Commission's decision. An applicant whose proposal is not approved may request a meeting with the Program administrator or Commission staff to discuss the basis for the Commission's decision.

(5) Hospitals approved for grant awards shall, upon authorization by the Commission, receive a proportion of the approved award on a monthly basis.

F. Required Report. A grant recipient hospital shall submit to the Commission, in the manner required by the Commission, a report on the expenditure of the grant funds. This report is due by September 1 after the close of the Commission's fiscal year in which the grant recipient received the funds.

.06 Failure or Delay in Paying Remittance Penalties.

A. The Commission may impose penalties of up to 5 percent of the amount of any underpayment, unless an extension is granted as provided in § E of this regulation.

B. A hospital that violates the provisions of Regulation .03 of this chapter shall, in addition to the penalties imposed under § A of this regulation, be subject to an annualized interest charge of 3 percentage points above the most recent average prime rate of interest, as published in the "*Money Rates*" section of *The Wall Street Journal*, on the unpaid balance.

C. In addition to the penalties the Commission may impose on a hospital that fails to pay the remittance in a timely manner, the Commission may refer the hospital's delinquent account to the Department of Budget and Fiscal Planning's Central Collection Unit pursuant to the procedures in State Finance and Procurement Article, Title 3, Subtitle 3, Annotated Code of Maryland.

D. A hospital may file a written request with the Commission for a reasonable extension of time to make payment if the extension request is:

- (i) Made in writing to the attention of the Executive Director;
- (ii) Supported by sufficient justification; and
- (iii) Made at a reasonable time before the due date of a required payment.

E. The Executive Director shall respond promptly in writing to the requesting hospital upon receipt of the request by either approving or disapproving the request.

F. Extensions will be granted only for valid reasons.