TITLE 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

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

Notice of Proposed Action

.26 [Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies] Working Capital Differentials — Payment of Charges.

[A. Hospital Information Sheet.

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

(a) Describes the hospital's financial assistance policy;

(b) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

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

(i) The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost, medically necessary care due to a financial hardship;

(iii) How to apply for free and reduced-cost care; and

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

(d) Provides contact information for the Maryland Medical Assistance Program;

(e) Includes a statement that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately;

(f) Informs patients that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee", for their use of hospital facilities, clinics, supplies and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(g) Informs patients of their right to request and receive a written estimate of the total charges for the hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital;

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

(i) Provides the patient with the contact information for filing the complaint.

(2) The information sheet shall be in:

(a) Simplified language in at least 10-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(3) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(a) Before the patient receives scheduled medical services;

(b) Before discharge;

(c) With the hospital bill;

(d) On request; and

(e) In each written communication to the patient regarding collection of the hospital bill.

(4) The hospital bill shall include a reference to the information sheet.

(5) The Commission shall:

(a) Establish uniform requirements for the information sheet; and

(b) Review each hospital's implementation of and compliance with the requirements of this section.

A-1. Hospital Credit and Collection Policies.

(1) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients.

(2) The policy shall:

(a) Prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained;

(b) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(c) Describe the hospital's procedures for collecting any debt;

(d) Describe the circumstances in which the hospital will seek a judgment against a patient;

(e) Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care on the date of service, in accordance §A-1(3) of this regulation;

(f) If the hospital, has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care on the date of the service for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacated the judgment or strike the adverse information;

(g) Provide a mechanism for a patient to file with the hospital a complaint against the hospital or an outside collection agency used by the hospital regarding the handling of the patient’s bill;

(h) Provide detailed procedures for the following actions:

(i) When a patient debt may be reported to a credit reporting agency;

(ii) When legal action may commence regarding a patient debt;

(iii) When garnishments may be applied to a patient’s or patient guarantor’s income; and

(iv) When a lien on a patient’s or patient guarantor’s personal residence or motor vehicle may be placed.

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

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

(b) A hospital may reduce the 2-year period under §A-1(3)(a) of this regulation to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient’s eligibility for free care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information; and

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

(4) For at least 120 days after issuing an initial patient bill, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill.

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

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

(7) If a hospital delegates collection activity to an outside collection agency, the hospital shall:

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

(b) Specify procedures the outside collection agency must follow if a patient appears to qualify for financial assistance; and

(c) Require the outside collection agency to:

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

(ii) If a patient files a complaint with the collection agency, forward the complaint to the hospital.

(8) The Board of Directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital every 2 years. A hospital may not alter its financial assistance or debt collection policies without approval by the Board of Directors.

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

A-2. Hospital Financial Assistance Responsibilities.

(1) Definitions.

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

(b) Terms Defined.

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

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

(2) Financial Assistance Policy.

(a) On or before June 1, 2009, each hospital and, on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. A hospital shall provide notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill. The financial assistance policy shall provide at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level;

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

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

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

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

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

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

(i) Households with children in the free or reduced lunch program;

(ii) Supplemental Nutritional Assistance Program (SNAP);

(iii) Low-income-household energy assistance program;

(iv) Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package;

(v) Women, Infants and Children (WIC); or

(vi) Other means-tested social services programs deemed eligible for hospital free care policies by the Maryland Department of Health and the HSCRC, consistent with HSCRC regulation COMAR 10.37.10.26.

(d) A hospital that believes that an increase to the income thresholds as set forth above may result in undue financial hardship to it may file a written request with the Commission that it be exempted from the increased threshold. In evaluating the hospital's request for exemption, the Commission shall consider the hospital's:

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of charity care provided; and

(v) Other relevant factors.

(e) Based on staff's evaluation of the written request for an exemption, the Executive Director shall respond in writing within a reasonable period of time approving or disapproving the hospital's exemption request.

(f) A hospital denied an exemption request shall be afforded an opportunity to address the Commission at a public meeting on its request. Based on arguments made at the public meeting, the Commission may approve, disapprove, or modify the Executive Director's decision on the exemption request.

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

(a) The hospital's financial assistance policy developed under this section; and

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

(i) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

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

(iii) The total number of patients who received financial assistance during the immediately preceding year, by race or ethnicity and gender;

(iv) The total number of patients who were denied financial assistance during the immediately preceding year, by race or ethnicity and gender;

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

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

(4) Financial Hardship Policy.

(a) Subject to §A-2(3)(b) and (c) of this regulation, the financial assistance policy required under this regulation shall provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

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

(c) In evaluating a hospital's request to establish a different family income threshold, the Commission shall take into account:

(i) The median family income in the hospital's service area;

(ii) The patient mix of the hospital;

(iii) The financial condition of the hospital;

(iv) The level of bad debt experienced by the hospital;

(v) The amount of the charity care provided by the hospital; and

(vi) Other relevant factors.

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

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

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

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

(6) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(7) The notice required under §A-2(6) of this regulation shall be in:

(a) Simplified language in at least 10-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

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

(9) Each hospital shall establish a mechanism to provide the Uniform Financial Assistance Application to patients regardless of their insurance status. A hospital may require from patients or their guardians only those documents required to validate the information provided on the application.

(10) Asset Test Requirements. A hospital may, in its discretion, consider household monetary assets in determining eligibility for financial assistance in addition to the income-based criteria, or it may choose to use only income-based criteria. If a hospital chooses to utilize an asset test, the following types of monetary assets, which are those assets that are convertible to cash, shall be excluded:

(a) At a minimum, the first $10,000 of monetary assets;

(b) A "safe harbor" equity of $150,000 in a primary residence;

(c) Retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans;

(d) One motor vehicle used for the transportation needs of the patient or any family member of the patient;

(e) Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and

(f) Prepaid higher education funds in a Maryland 529 Program account.

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

(12) In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

(a) A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

(b) Biological children, adopted children, or stepchildren; and

(c) Anyone for whom the patient claims a personal exemption in a federal or State tax return.

(13) For a patient who is a child, the household size shall consist of the child and the following individuals:

(a) Biological parents, adoptive parents, stepparents, or guardians;

(b) Biological siblings, adopted siblings, or step siblings; and

(c) Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

A-3. Patient Complaints. The Commission shall post a process on its website for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of Health-General Article, §19-214.1 or 19-214.2, Annotated Code of Maryland. The process established shall include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit. The process shall conform to the requirements of Health-General Article, §19-214.3, Annotated Code of Maryland.

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

A. For purposes of this regulation, the terms "debt collector", "hospital", "income-based payment plan", and "payment plan" have the meaning given such terms in COMAR 10.37.13.01.

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

[(a)**]** *(1)* A third-party payer that provides current financing equal to the average amount of outstanding charges for bills from the end of each regular billing period and for discharged patients shall be entitled to a 2-percent discount. For purposes of this regulation, a regular billing period shall be based on a 30-day billing cycle. The current financing provided **[**in here**]** *to hospitals* corresponds to a third party's paying on discharge.

[(b)**]** *(2)* A third-party payer that provides current financing equal to the average amount of outstanding charges for discharged patients plus the average daily charges times the average length of stay, shall be entitled to a 2.25-percent discount. The current financing provided **[**in here**]** *to hospitals* corresponds to a third party's paying on admission.

[(c)**]** *(3)* Outstanding charges shall be calculated by an amount equal to the hospital's current average daily payment by the payer, multiplied by the hospital's and third party payer's processing and payment time. The precise calculation shall be made in accordance with the guidelines specified by Commission staff.

[(d)**]** *(4)* Upon request from an applicant, the Commission may approve an alternative method of calculating current financing monies.

[(e)**]** *(5)* The third-party payer shall adjust the current financing advance to reflect Commission rate orders and changes in volume associated with the particular payer and hospital. This adjustment shall be made within 45 days of a rate order or at such other time as circumstances warrant. In the absence of a rate order, the adjustment shall be made at least annually.

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

[(3)**]** *D.* A payer or self-paying patient, who does not provide current financing under §B**[**(1)(a)—(e)**]** of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that. *For patients that have entered into a hospital income-based payment plan under COMAR 10.37.13.05 , the interest rate shall be established in accordance with the Guidelines.*

[(4)**]** *E.* Hospital Billing Responsibilities.

(1) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal (when dismissal for outpatients is analogous to discharge for inpatients).

(2) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and, excepting arithmetic errors, represent the full charge for the patient's care.

(3) A notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts referred to in D. of this regulation.

(4) The bill and the notice shall state that the patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days.

[(a) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal (when dismissal for outpatients is analogous to discharge for inpatients).

(b) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and excepting arithmetic errors, represent the full charge for the patient's care. In addition, a notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts mentioned above.

(c) The bill and the notice shall state that the:

(i) Charge is due within 60 days of discharge or dismissal;

(ii) Patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days; and

(iii) Payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, may be subject to interest or late payment charges at a rate of 1 percent per month beginning on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(5) Hospital Written Estimate.

(a) On request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

(b) The written estimate shall state clearly that it is only an estimate and actual charges could vary.

(c) A hospital may restrict the availability of a written estimate to normal business office hours.

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

C.**]** *F.* GME Discounts. In those instances where a teaching hospital is reimbursed separately for the costs associated with the provision of graduate medical education (GME), the Commission shall calculate the percentage of the hospital's rates that these GME payments represent and provide notice of the amounts that may be credited toward the payment for services rendered. At all times, total payment received by the teaching hospital shall be in accordance with Commission-approved rates.

TITLE 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.13 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies

Authority: Health-General Article, §§19-214.2, 19-214.3, 19-207 and 19-219 Annotated Code of Maryland

Notice of Proposed Action

.01 Definitions

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

B. Terms Defined:

(1) "Adjusted gross income" means total income, before taxes. If a hospital uses state or federal tax returns to verify income, hospitals shall take into consideration adjustments listed on Schedule 1 of Form 1040.

(2) "Credit and collection policy" means a hospital's policy on the collection of medical debt.

(3) Debt Collector.

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

(i) Collecting for, or soliciting from another, medical debt;

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

(iii) Employing the services of an individual or business to solicit or sell a collection system to be used for collection of medical debt.

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

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

(5) "Hospital" means a facility defined in Md. Code Ann., Health-Gen. §19- 301(f).

(6) "Hospital services" means:

(a) Inpatient hospital services as enumerated in Medicare Regulation 42 C.F.R. § 409.10, as amended;

(b) Emergency services, including services provided at a freestanding medical facility licensed under Subtitle 3A of title 19 of Md. Code Ann., Health-Gen. ;

(c) Outpatient services provided at a hospital (as defined in COMAR 10.37.10.07-01);

(d) Outpatient services, as specified by the Commission in COMAR 10.37.10.07-02, provided at a freestanding medical facility licensed under Subtitle 3A of title 19 of Md. Code Ann., Health-Gen. that has received:

(i) A certificate of need under Md. Code Ann., Health-Gen § 19–120(o)(1); or

(ii) An exemption from obtaining a certificate of need under Md. Code Ann., Health-Gen §19–120(o)(3); and

(e) Identified physician services for which a facility has Commission–approved rates on June 30, 1985.

(f) "Hospital services" includes a hospital outpatient service:

(i) Of a hospital that, on or before June 1, 2015, is under a merged asset hospital system;

(ii) That is designated as a part of another hospital under the same merged asset hospital system to make it possible for the hospital outpatient service to participate in the 340B Program under the federal Public Health Service Act; and

(iii) That complies with all federal requirements for the 340B Program and applicable provisions of 42 C.F.R. § 413.65.

(g) "Hospital services" does not include:

(i) Outpatient renal dialysis services; or

(ii) Outpatient services provided at a limited service hospital as defined in Md. Code Ann., Health-Gen § 19–301, except for emergency services; or

(iii) Physician services that are billed separately.

(7) Household.

(a)"Household" means, at a minimum:

(1) For an adult patient, the patient and the following individuals:

(i) A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

(ii) Biological children, adopted children, or stepchildren; and

(iii) All individuals on the same federal or State tax return, including anyone for whom the patient claims a personal exemption in a federal or State tax return.

(2) For a patient who is a child, the patient and the following individuals:

(i) Biological parents, adoptive parents, stepparents, or guardians;

(ii) Biological siblings, adopted siblings, or step siblings; and

(iii) All individuals on the same federal or State tax return, including anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

(b) The terms "household" and "family" are synonymous for the purposes of this regulation.

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

(9) "Medical debt" means out-of-pocket expenses, including co-payments, coinsurance, and deductibles, for hospital services that are regulated by HSCRC that are billed to a patient or a co-signer for the patient, excluding amounts contractually paid by another payer (e.g. insurers, Medicare, Medicaid, or CHIP).

(10) "Medically necessary care" means care that is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;

(b) Consistent with current accepted standards of good medical practice;

(c) Not primarily for the convenience of the patient, the patient's family, or the provider; and

(d) Care provided in accordance with the Emergency Medical Treatment and Labor Act of 1986 ("EMTALA").

(11) "Monetary assets" means assets in excess of $100,000 that can readily be converted into a fixed or precisely determinable amount of money, including cash and cash equivalents, such as cash on hand, bank deposits, investment accounts, accounts receivable (AR), and notes receivable. Monetary assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment.

(12) "Payment plan" means an agreement between a patient (or a guarantor) to pay for a hospital service over a period of time, including an "income-based payment plan" under regulation .05 of this chapter and a "non-income-based payment plan" under §W of regulation .05 of this chapter.

(13) "Written" Communications.

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

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

.02 Electronic Delivery of Written Communications

A. A patient may opt out of receiving written communications required by regulations .03 through .08 of this chapter through electronic delivery methods (such as through email or a patient portal).

B. A hospital or debt collector who communicates with a patient electronically must include in such communication, or attempt to communicate, a clear and conspicuous statement describing a reasonable and simple method by which the patient can opt out of further electronic communications by the hospital or debt collector.

C. A hospital or debt collector may not require, directly or indirectly, that the patient, in order to opt out of electronic communication, pay any fee or provide any information other than the patient's opt out preferences and the email address, telephone number for text messages, or other electronic-medium address subject to the opt-out request.

D. If a hospital or debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the hospital or the debt collector:

(1) may not provide the written communications required by regulations .03 through .09 of this chapter through electronic delivery methods; and

(2) must deliver the written communications through non-electronic delivery methods.

E.

(1) If a hospital receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, and the hospital uses a debt collector with respect to that patient, the hospital must immediately inform the debt collector that the patient is opting out of electronic delivery methods.

(2) If a debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the debt collector must immediately inform the hospital that controls that patient account that the patient is opting out of electronic delivery methods.

.03 Hospital Information Sheet

A. Each hospital shall develop an information sheet that:

(1) Describes clearly:

(a) the hospital's financial assistance policy as required in regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(b) a patient's legal rights and obligations with regard to hospital billing and collection.

(2) Informs the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(a) that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee", for their use of hospital facilities, clinics, supplies and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(b) of the patient's right to request and receive a written estimate of the total charges for the hospital non-emergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital, in addition to the good faith estimate requirements in the Public Health Service Act § 2799B-6, the No Surprises Act;

(c) of the patient's right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland;

(d) of the availability of an income-based payment plan;

(e) that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately;

(3) Provides contact information for:

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

(i)The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost, medically necessary care due to a financial hardship;

(iii) How to apply for financial assistance;

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

(v) How to apply for a payment plan;

(b) the Maryland Medical Assistance Program;

(c) filing a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland;

(4) Includes a section that allows the patient to initial that the patient has been made aware of the financial assistance policy.

B. The information sheet shall be in:

(1) Simplified language in at least 12-point type; and

(2) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

C. The information sheet shall conform with Health-General Article, §19–342(d)(7) and (10), Annotated Code of Maryland.

D. The information sheet shall be provided in writing to the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(1) Before the patient receives scheduled medical services;

(2) Before discharge;

(3) With the hospital bill;

(4) On request; and

(5) In each written communication to the patient regarding collection of the hospital bill.

E. The hospital bill shall include a reference to the information sheet.

F. The Commission shall:

(1) Establish uniform requirements for the information sheet; and

(2) Review each hospital's implementation of and compliance with the requirements of this regulation.

.04 Hospital Credit and Collection Responsibilities.

A. Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's credit and collection policy.

B. The policy shall:

(1) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(2) Prohibit the hospital from selling any debt, except as permitted by Health-General Article, §19–214.2(m) and §O of this regulation, Annotated Code of Maryland;

(3) Prohibit the hospital from:

- *(a) Engaging in collection activities on 100 percent of the outstanding amount of the Commission-set charge for debt sold under §O of this regulation and Health-General Article, §19-214.2(m); and*
- *(b) Collecting on judgments entered into on patient debt that was sold under §O of this regulation and Health-General Article, §19-214.2(m).*
- *(c) Reporting adverse information to a consumer reporting agency;*
- *(d) Filing a civil action to collect a debt against a patient within 240 days after the initial bill is provided;*
- *(e) Filing a civil action to collect a debt against a patient whose outstanding hospital medical debt is at or below $500;*

(4) In accordance with Health-General Article, §19-214.2(c) and section G. of this regulation, Annotated Code of Maryland, provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free medically necessary care within 240 days after the initial bill was provided under Health General 19-214.1 and §G of this regulation;

(5) If the hospital has obtained a judgment against or had reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free medically necessary care, in accordance with regulation .06 of this

chapter and Health-General Article, §19-214.1, Annotated Code of Maryland, within 240 days after the initial bill was provided, require the hospital to seek to vacate the judgment or strike the adverse information;

(6) Provide a mechanism for a patient to:

(a) Request the hospital to reconsider the denial of free or reduced–cost care;

(b) File with the hospital a complaint against the hospital or a debt collector used by the hospital regarding the handling of the patient's bill; and

(7) For a patient who is eligible for free or reduced cost-care under the hospital's financial assistance policy, prohibit the hospital from:

(a) charging interest on the debt owed on a bill for the patient before a court judgement is obtained; or

(b) collecting fees or any other amount that exceeds the approved charge for the hospital service as established by the Commission.

(8) Establish a process for making payment plans available to all patients in accordance with regulation .05 of this chapter and Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland.

(9) Provide detailed procedures for the following actions:

(a) When garnishments may be applied to a patient's or patient guarantor's income in accordance with section .04I of this regulation and Health-General Article, §19-214.2(f)(4), Annotated Code of Maryland;

(b) When a lien on a patient's or patient guarantor's personal residence, excluding a primary resident in accordance with section .04I. of this regulation and Health-General Article, §19-214.2(g)(2), Annotated Code of Maryland, or motor vehicle may be placed;

(c) the hospital's procedures for collecting any medical debt, consistent with section .04 of this regulation;

(d) the circumstances in which the hospital will seek a judgment against a patient for the patient's medical debt, subject to §.04 I. of this regulation and Health-General Article, §19–214.2, Annotated Code of Maryland;

(e) the consideration by the hospital of patient income, assets, and other criteria under section .04 of this regulation;

(10) Comply with Health-General Article, §24-2502, Annotated Code of Maryland.

C. Consistent with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, a hospital shall demonstrate that it attempted in good faith to meet the requirements of Health-General Article, §19-214.2(e), Annotated Code of Maryland and the Guidelines with regulation .05 of this chapter before the hospital:

(1) Files an action to collect the patient's medical debt; or

(2) Delegates collection activity to a debt collector for a patient's medical debt.

D. The hospital shall be deemed to have demonstrated that it attempted to act in good faith under Health-General Article, §19-214.2(e)(5)(i)(2), Annotated Code of Maryland and §C(2) of this regulation if, before delegating collection of a patient's medical debt to a debt collector, the hospital:

(1) Provides the information sheet before the patient receives scheduled medical services and before discharge in accordance with Health-General Article, §19-214.2(e)(1) and (2), Annotated Code of Maryland, and in §D(1) and (2) of regulation .03 of this chapter ; and

(2) Establishes a process for making payment plans available to all patients in accordance with Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland, and regulation .05 of this chapter;

E. In delegating any or all collection to a debt collector for a patient's medical debt, the hospital may rely on a debt collector to engage in various activities, including:

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

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

F. A hospital may not seek legal action to collect a patient's medical debt until the hospital has established and implemented a payment plan policy that complies with the Guidelines.

G. As provided by Health-General Article, §19-214.2(c):

(1)(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who was found to be eligible for free medically necessary care within 240 days after the initial bill is provided to the patient;

(b) The hospital shall provide the refund to the patient not later than 30 days after determining that the patient was eligible for free medically necessary care.

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

H. Consumer Reporting.

(1) A hospital may not commence civil action against a patient for nonpayment or delegate collection activity to a debt collector, if the hospital:

(a) Was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days;

(b) Is processing a requested reconsideration of the denial of free or reduced-cost medically necessary care under §A(1)(c)(v) of regulation .06 of this chapter and Health-General Article, §19-214.1(b)(2)(iv), Annotated Code of

Maryland, that was appropriately completed by the patient or has completed the reconsideration within the immediately preceding 60 days; or

(c) If the hospital sold the debt under §O of this regulation and Health-General Article, §19-214.2(m).

(2) A hospital shall comply with Health-General Article, §24-2502, Annotated Code of Maryland;

(3) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient, including if the debt was sold under §O of this regulation and Health-General Article, §19-214.2(m)

(4) Not later than November 1, 2025, a hospital that had reported adverse information about a patient to a consumer reporting agency shall instruct the consumer reporting agency to delete the adverse information about the patient.

I. Civil Action

(1) Primary Residences

(a) A hospital may not force the sale or foreclosure of a patient's primary residence to collect the medical debt.

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

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

(a) A body attachment against a patient; or

(b) An arrest warrant against a patient.

(3) A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect medical debt if the patient is eligible for free or reduced-cost medically necessary care, in accordance with regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland.

(4) Deceased patients.

(a) A hospital may not make a claim against the estate of a deceased patient to collect medical debt if the deceased patient was known by the hospital to be eligible for free medically necessary care, in accordance with regulation .06 of this chapter and Health-General article, §19-214.1, Annotated Code of Maryland, or if the value of the estate after tax obligations are fulfilled is less than half of the medical debt owed.

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

(5) A hospital may not file an action to collect medical debt until the hospital determines whether the patient is eligible for free or reduced-cost medically necessary care under regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland.

(6) At least 45 days before filing an action against a patient to collect medical debt, but not within 240 days after the initial bill is provided, a hospital shall send written notice of the intent to file an action to the patient. The notice shall:

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

(b) Be in simplified language and in at least 12-point type;

(c) Include:

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

(ii) The amount required to cure the nonpayment of medical debt, including past due payments, interest, penalties, and fees;

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

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

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

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

(e) Be accompanied by:

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

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

(ii) The information sheet required under regulation .03 of this chapter and Health-General Article, §19-214.1(f), Annotated Code of Maryland.

J. If a hospital delegates collection activity to a debt collector, the hospital shall:

(1) Specify the collection activity to be performed by the debt collector through an explicit authorization or contract;

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

(3) Specify procedures the debt collector must follow if a patient appears to qualify for financial assistance under regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(4) Require the debt collector to:

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

(b) If a patient files a complaint with the debt collector, forward the complaint to the hospital; and

(c) Along with the hospital, be jointly and severally responsible for meeting the requirements of this regulation and regulation .06 of this chapter and Health-General Article, §19-214.2, Annotated Code of Maryland.

K. A spouse or another individual may not be held liable for the medical debt of an individual 18 years old or older unless the individual voluntarily consents to assume liability for the patient's medical debt. The consent shall be:

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

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

(3) Not required as a condition of providing emergency or non-emergency health care services.

L. The Board of Directors of each hospital shall review and approve the hospital's financial assistance policy required under regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland and debt collection policy required under regulation .04 of this chapter and Health-General Article, §19-214.2, Annotated Code of Maryland at least every 2 years. A hospital may not alter its financial assistance or credit and collection policies without approval by the Board of Directors.

M. The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of §B of this regulation.

N. Reporting Requirements.

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

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

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

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

(d) For hospital debts owed by patients of the hospital that the hospital sold to a governmental unit, contractor, or nonprofit organization under Health-General Article, §19-214.2(m), Annotated Code of Maryland and §O:

(i) The total dollar amount of the debt sold by the hospital for the reporting year;

(ii) The total dollar amount paid by the hospital to the unit, contractor, or nonprofit organization who purchased the debt; and

(iii) The total number of patients whose debt was sold, in full or in part, to the unit, contractor, or nonprofit organization who purchased the debt.

(2) The Commission shall post the information submitted under §N(1) of this regulation on its website.

O. Selling Medical Debt.

(1) Consistent with Health-General Article, §19-214.2(m), Annotated Code of Maryland, a hospital may sell debt owed to the hospital by a patient for hospital services to a governmental unit, an entity that is under contract with the governmental unit, or to a nonprofit organization that is exempt from taxation under §501(c)(3) of the Internal Revenue Code for the sole purpose of canceling the debt.

(2) The contract between the hospital and the governmental unit, entity that is under contract with the governmental unit, or nonprofit organization purchasing the debt shall state that the sole purpose of the sale of the debt is to cancel the debt.

(3) The patient is not responsible to the hospital, the governmental unit, the entity that is under contract with the governmental unit, or the nonprofit organization for any amount of the debt that is sold, or any interest, fees, or costs associated with the debt or the sale.

(4) Debt sold under this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland:

(a) Must be for hospital services provided at least 2 years before the date of the sale;

(b) May not be expected to yield additional reimbursements from a third-party payor;

(c) May not be subject to an open appeal with an insurance company; and

(d) Must be for an individual whose family income is at or below 500 percent of the federal poverty level or who has medical debt exceeding 5 percent of the patient's family income, as determined by the governmental unit, contractor, or nonprofit organization purchasing the debt.

(5) Debt sold under this Regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland may be sold with a reduction of Commission charges.

(6) The Commission shall treat the amount of payments to hospitals under this subsection as an offset to uncompensated care amounts reported by hospitals.

(7) The purchaser of the debt shall:

(a) Notify the patient that the debt has been canceled; and

(b) If the hospital obtained a judgment against the patient or reported adverse information to a consumer reporting agency about the patient, seek to vacate the judgment or strike the adverse information.

(8) If a hospital sells hospital medical debt under this regulation and Health-General Article, §19-214.2(m), the hospital must immediately dismiss actions pending against a patient for collection of that debt.

.05 Guidelines for Hospital Payment Plans.

A. Scope.

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

(2) "Income" in this section means adjusted gross income:

(a) that is taxable;

(b) at the household level; and

(c) at the monthly level.

(3) Prepayment Plans. Nothing in the Guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that:

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

(b) Before a hospital requests pre-payment for a hospital service, the hospital shall:

(i) Comply with the notice provisions of Health General 19-214.1 and regulation .03 and .06 of this chapter;

(ii) Advise the patient about the availability of financial assistance;

(iii) Process any request for financial assistance; and

(iv) Advise the patient about the availability of income-based payment plans, including information about the 5 percent cap on monthly payment amounts under §F(1) of this regulation; and

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

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

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

B. Access to Income-Based Payment Plans.

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

(a) Insurance status;

(b) Citizenship status;

(c) Immigration status; or

(d) Eligibility for reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, under regulation .06 of this chapter.

(2) Treatment of Nonresidents and Unregulated Services.

(a) These Guidelines do not prevent a hospital from extending payment plans to patients who are not described in §B(1) of this regulation.

(b) These Guidelines do not prevent a hospital from extending payment plans to patients for services that are not regulated by the HSCRC.

(c) Except as required by §W of this regulation or by other law or regulation, payment plans for patients who are not described in §B(1) of this regulation and payment plans for services that are not regulated by the HSCRC are not subject to the Guidelines under this regulation.

C. Notice Requirements.

(1) Notice of Availability of an Income-Based Payment Plan.

(a) Posted Notice.

(i) A notice shall be posted in conspicuous places throughout the hospital, including the billing office, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital for additional information.

(ii) If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection (such as a debt collector or eligibility vendor), the hospital shall ensure that the vendor posts a notice in a conspicuous place on their website or online payment portal, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital or debt collector for additional information. Placement on the website or online payment portal should be based on the best interest of the patient.

(b) Information Sheet. A written notice of the availability of an income-based payment plan shall be contained in the information sheet required under regulation .03 of this chapter, including clarity on the availability of income-based payment plans for Maryland residents, and, if payment plans for non-residents are included in the hospital's credit and collection policy, the availability of such plans for non-residents.

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

(d) On a Bill. On the same page of the bill that includes the amount due and due date, the hospital shall provide notice that a lower monthly payment amount may be possible through an income-based plan, in the same font and style as the total amount due notification.

(e) Online Payment Portal. On both the page of the online payment portal that states the amount due, and where the consumer enters the amount being paid by the consumer, the hospital shall provide, in the same font and style as the amount due notification, notice informing Maryland residents of the availability of an income-based monthly payment plan and information, including a telephone number and email address, in order to contact the hospital for additional information.

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

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

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

(c) The amount of each periodic payment expected from the patient under the income-based payment plan;

(d) The number of periodic payments expected from the patient under the income-based payment plan;

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

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

(g) The treatment of any missed payments, including missed payments and default as described in §Q and U of this regulation;

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

(i) Whether the hospital plans to apply a periodic recalculation of monthly payment amounts as described in §P of this regulation and the process for such recalculation;

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

D. Financial Assistance. Before entering into an income-based payment plan with a patient, a hospital shall evaluate if the patient is eligible for financial assistance, including free and reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, in accordance with regulation .06 of this chapter. The hospital will apply the financial assistance reduction before entering into an income-based payment plan with a patient.

E. Offer Required. Hospitals must offer income-based payment plans that meet the requirements of these Guidelines.

F. Monthly Payment Amounts.

(1) Under an income-based payment plan subject to these Guidelines, a hospital may not require a patient to make total payments in a month that exceed 5 percent of the lesser of the patient's household income.

(2) §F(1) applies to total amounts due under the plan, including both principal and interest, but does not apply to any catch-up payments, such as payments described under §Q(1) of this regulation.

(3) A hospital shall calculate the monthly payment amount threshold under §F(1) of this regulation by dividing income level by household size and multiplying by .05 percent.

(4) Determining the Household Size. The hospital shall determine the size of the patient's household using the number reported on tax returns, if provided the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of individuals in the household.

G. Income Documentation.

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

(2) If the patient has not provided their tax returns, pay stubs, W2s, or another form of documentation,the hospital shall use available information, including information provided by the patient, to approximate the patient's income.

(3) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation. Such an attestation shall include the patient's income and the number of filers and dependents on their tax return. If the patient provides an attestation of income the hospital is not required to conduct any additional income verification.

(4) A hospital's inability to obtain the complete income information does not preclude the hospital's ability to reasonably predict a patient's income based on the information provided. For example, a hospital may divide income reported at the annual level by twelve to determine income at the monthly level.

H. Expenses. A hospital shall consider information provided by a patient about household expenses in determining the amount of the monthly payment due under an income-based payment plan.

I. Application to Multiple Income-based Payment Plans.

(1) Hospitals. A hospital shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by the hospital, when added up collectively, does not exceed the income limitation under §F(1) of this regulation.

(2) Hospital System. A hospital system shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, does not exceed the income limitation under §F(1) of this regulation.

J. Duration of Income-Based Payment Plan. The duration of an income-based payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5 percent of the patient's income as calculated under §F(1)of this regulation.

K. Solicitation of Early Payments Prohibited. Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in an income-based payment plan.

L. Application of Partial Payments. A hospital shall apply partial payments in a manner most favorable to the patient.

M. Interest and Fees.

(1) No Interest for Patients Eligible for Financial Assistance. For a patient who is eligible for free or reduced-cost medically necessary care under the hospital's financial assistance policy under regulation .06 of this chapter and Health-General Article, §19–214.1 Annotated Code of Maryland, the hospital may not charge interest or fees on any medical debt amount owed under an income-based payment plan;

(2) Interest Allowed. A hospital may charge interest under an income-based payment plan for a patient who is not eligible for free or reduced-cost medically necessary care, as described in §M of this regulation. A hospital is not required to charge interest for a payment plan.

(3) Interest Rate. An income-based payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization. Payers subject to Insurance Article, §15-1005, Annotated Code of Maryland, shall comply with its provisions.

(4) Timing. Interest may not begin before 240 days after the initial bill is provided.

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

N. Early Payment.

(1) Prepayment Allowed.

(a) Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under an income-based payment plan.

(b) Any prepayment made under §N(1) of this regulation is not subject to the monthly income payment limitations of §F(1) of this regulation.

(2) No Fees or Penalties. A hospital may not assess fees or otherwise penalize early payment of an income-based payment plan.

O. Limited Modifications of Income-based Payment Plans.

(1) Change in Income. If a patient with an income-based payment plan notifies a hospital that the patient's income has changed then the hospital shall offer to modify the income-based payment plan to meet the requirement of §O(6) of this regulation.

(2) Expenses. Before modifying an income-based payment plan, a hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

(3) No Increase in Interest Rate. A hospital may not increase the interest rate on an income-based payment plan when making a modification to an income-based payment plan under this guideline.

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

(5) Change in Duration. The duration of a modified income-based payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation under §F of this regulation.

(6) Process for Modifying an Income-Based Payment Plan.

(a) Prompt Response to Patient Request. If a patient requests a modification to the terms of the payment plan, the hospital shall respond in a timely manner and may not refer the outstanding balance owed to a collection agency or for legal action until 30 days after providing a written response to the patient's request for a modification of the payment plan.

(b) Reconsideration for Financial Assistance. If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance, including free medically necessary care, reduced-cost

medically necessary care, and reduced-cost care due to financial hardship under regulation .06 of this chapter. The hospital will apply the financial assistance reduction in its modification of the payment plan.

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

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

P. Hospital-Initiated Changes to Income-Based Payment Plans Based on Changes to Patient Income.

(1) Recalculation Allowed. A hospital may, in the terms of an initial income-based payment plan under §C(2) of this regulation that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as subject to and calculated under §O(5) of this regulation.

(2) Notice Included in Initial Income-Based Payment Plan. The hospital may only recalculate payment amounts under an income-based payment plan if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the income-based payment plan, in accordance with §C(2) of this regulation. The patient's agreement to enter into the income-based payment plan after receiving that notice constitutes consent to the payment recalculations allowed under §P of this regulation.

(3) Limitations on Modification Apply. The provisions of §O of this regulation relating to limitations of payment plan modifications apply to payment recalculations for income-based payment plans under §P of this regulation.

(4) Frequency of Recalculation. A hospital may not seek a recalculation of the monthly payment amount under an income-based payment plan, as provided for under §P(1) of this regulation more often than once every 3 years.

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

Q. Treatment of Missed Payments.

(1) First Missed Payment.

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

(b) Subject to §Q(1)(c) of this regulation, the hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

(c) No later than 30 days after the first missed payment in a 12-month period, the hospital shall notify the patient of the missed payment and inform the patient that the patient may be in default if they do not pay the amount of the missed payment within 12 months or if they miss additional payments within the 12-month period. The notice will give the patient the option to pay the missed payment by paying the amount of the missed payments in one of the following ways:

(i) 11 increments over the subsequent 11 months;

(ii) a single payment; or

(iii) Another approach, as specified by the patient.

(d) With respect to a patient that has missed a single monthly payment in a 12-month period, the hospital shall provide the patient with a method to designate whether any amount of a payment paid in the subsequent 12-month period is to be applied to the amount of missed payment or applied in a different manner.

(e) With respect to a patient that has missed a single monthly payment in a 12-month period, if the hospital receives a payment and the patient has not designated how that payment is to be applied, the hospital shall first apply the amount to any payment that is due in the 31-day period following the date the payment is received. If there is no payment due in the next month, the hospital shall apply the amount of the payment to the missed payment. If the amount of the payment exceeds the amount of any payment that is due in the 31-day period following the date the payment is received, the excess amount shall be applied to the missed payment.

(f) The hospital may consider a patient to be in default on the income-based payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under §Q(1) of this regulation.

(2) Additional Missed Payments.

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

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

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

(d) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this §Q of this regulation as additional payments at the end of the income-based payment plan, thereby extending the length of the income-based payment plan.

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

R. Treatment of Loans and Extension of Credit. After a hospital service is provided to the patient, a hospital, hospital affiliate, or third-party in partnership with a hospital may not make any loan or extension of credit to the patient in connection with a medically necessary hospital service that is inconsistent with the guidelines for payment plans in this regulation resulting from that service.

S. Application of Credit Provisions of Maryland Commercial Law Article and Licensing Provisions of Financial Institutions Article. An income-based payment plan is an extension of credit subject to Maryland credit regulations under Commercial Law Article, Title 12, Annotated Code of Maryland and any applicable licensing provisions of Financial Institutions Article, Title 11, Annotated Code of Maryland.

T. Books and Records. A hospital shall retain books and records on income-based payment plans for at least 3 years after the income-based payment plan is closed.

U. Default.

(1)If a patient defaults on an income-based payment plan and the parties are not able to agree to a modification, then the hospital shall follow the provisions of its credit and collection policy established in accordance with regulation .04 of this chapter, before a hospital may write this medical debt off as bad debt.

(2) With respect to the amounts covered by the income-based payment plans, a patient who is on an income-based payment plan and is not in default on that payment plan may not be considered in arrears on their debt to the hospital when the hospital is making decisions about scheduling health care services.

V. Non-Income-Based Payment Plans.

(1) Other Payment Plans Allowed. A hospital may offer a non-income-based payment plan under these guidelines, but must first offer the patient an income-based payment plan.

(2) Application of Guidelines: Consistent with the guidelines for hospital payment plans and consistent with the intent of Health General 19-214.2, the following provisions of this regulation apply to non-income-based payment plans in the same manner such provisions apply to income-based payment plans:

(a) §A of this regulation, regarding scope;

(b) §B of this regulation , regarding access to payment plans;

(c) §C(2) of this regulation, regarding notice of payment plan terms before execution;

(d) §C(3) of this regulation, regarding notice of plan after execution;

(e) §D of this regulation, regarding financial assistance;

(f) §M of this regulation, regarding interest and fees;

(g) §N(1)(a) and (2) of this regulation, regarding early payments;

(h) §O(6) of this regulation, regarding modifications of payment plans;

(i) §R of this regulation, relating to treatment of loans and extensions of credit;

(j) §S of this regulation, relating to the application of credit provisions of Maryland Commercial Law Article and the licensing provisions of Financial Institutions Article;

(k) §T of this regulation, relating to books and records; and

(l) §U of this regulation, relating to default.

(3) Notice

(a) Notice of Terms Before Execution: In addition to complying with the terms of §C(2) of this regulation, the hospital must include notice that the patient may apply for an income-based payment plan at any time in the notice of terms before execution of a non-income-based payment plan.

(b) Notice of Plan After Execution: The hospital must include the notice required in §V(3)(a) of this regulation in the notice of the payment plan after execution that is required by §C(3) of this regulation.

(c) Notice with Bills: Each bill for a non-income-based payment plan shall include a notice that informs the patient that income-based payment plans are available, which could result in lower monthly payments and provides information on how to apply for such plans.

(4) Consent. Before entering into a non-income-based repayment plan with a patient, the hospital must obtain consent from the patient that records that the patient agrees to the following:

(a) The hospital offered the patient an income-based payment plan.

(b) The income-based payment plan limits monthly payment amounts to 5 percent of the patient's monthly income.

(c) The income-based payment plan may result in lower monthly payment amounts than the monthly payment amounts under the non-income-based repayment plan.

(d) The patient has the opportunity to disclose their income and determine the payment amount under the income-based payment plan.

(e) The patient is declining to enter an income-based payment plan and is consenting to enter a non-income-based repayment plan.

(5) Modification of a Non-Income-Based Payment Plan: In addition to complying with the terms of §O(6) of this regulation, before modifying a non-income-based payment plan-

(a) the hospital shall offer the patient an income-based payment plan; and,

(b) if the patient declines the income-based payment plan, obtain the consent required under §V(4) of this regulation.

(6) Default.

(a) If the patient defaults on a non-income-based payment plan, the hospital must offer an income-based payment plan to the patient before the hospital follows the provisions of its credit and collection policy to collect the debt.

(b) The offer under §V(6)(a) must be sent separately from a bill.

W. Steering:

(1) A hospital may not steer patients to non-income-based payment plans, or third-party credit providers, in such a manner that discourages patients from entering into income-based payment plans.

(2) A hospital may not steer patients to revolving credit products in such a manner that discourages patients from entering into either income-based payment plans or non-income based payment plans under this regulation.

.06 Hospital Financial Assistance Responsibilities.

A. Financial Assistance Policy.

(1)(a) Each hospital and each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost medically necessary care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill.

(b) A hospital shall provide written notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill.

(i) The required notice shall state that the patient has up to 240 days after the day the patient receives the initial hospital bill to apply for financial assistance from the hospital

(ii) The hospital shall obtain documentation ensuring that the patient or the patient's authorized representative acknowledges the patient's receipt of the notice before discharging the patient.

(iii) If a patient chooses not to apply for financial assistance, the patient's documented acknowledgement shall indicate that the patient is not applying for financial assistance on the day of the acknowledgment but may apply within 240 days immediately following the patient's receipt of the initial hospital bill

(c) The financial assistance policy shall provide at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level, consistent with the provisions of section (a)(2) below;

(ii) Reduced-cost medically necessary care to patients with family income between 200 and 300 percent of the federal poverty level, consistent with the provisions of section (a)(2) below;

(iv) A description of the payment plan required under Health-General Article, §19-214.2(d), Annotated Code of Maryland, and regulation .05 of this chapter; and

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

(d) If a patient is eligible for reduced–cost medically necessary care under paragraph (c)(ii) of this regulation, the hospital shall, at a minimum, reduce the patient's out-of-pocket expenses for the hospital services:

(i) For a patient with family income of at least 201% but not more than 250% of the federal poverty level, by 75%; and

(ii) For a patient with family income of more than 250% but not more than 300% of the federal poverty level, by 60%.

(e) The hospital shall provide free and reduced cost medically necessary care to all qualified Maryland residents, regardless of their citizenship or immigration status.

(f) The hospital shall provide free and reduced cost medically necessary care under §A(1)(c)) of this regulation to all qualified Maryland residents, regardless of whether the patient resides in the hospital's service area.

(g) The financial assistance policy applies to all medically necessary hospital services provided to qualified Maryland residents. Hospitals may not exclude non-urgent or elective, but medically necessary, care from their financial assistance policy.

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

(3) The hospital shall consider any change in the patient's financial circumstance in accordance with Health-General Article, §19-214.1(b)(11).

(4) A hospital's inability to obtain complete income information does not preclude the hospital's ability to reasonably predict a patient's income for the purposes of providing financial assistance. For example, a hospital may multiply income

reported at the monthly level by 12 to determine income at the annual level, allowing for reasonably predictable changes in income throughout the year.

(5) Presumptive Eligibility for Free Medically Necessary Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free medically necessary care:

(a) Households with a child in the free or reduced lunch program and is eligible for the program based on the household's income;

(b) Supplemental Nutritional Assistance Program (SNAP);

(c)Low-income-household energy assistance program;

(d)Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package;

(e)Women, Infants and Children (WIC); or

(f) Other means-tested social services programs deemed eligible for hospital free medically necessary care policies by the Maryland Department of Health and the HSCRC, consistent with this regulation.

B. Hospital Reports. Each hospital shall submit to the Commission within 120 days after the end of each hospital's fiscal year:

(1) The hospital's financial assistance policy developed under this section; and

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

(a) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

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

(c) The total number of patients who received financial assistance during the immediately preceding year, by race or ethnicity and gender;

(d) The total number of patients who were denied financial assistance during the immediately preceding year, by race or ethnicity and gender;

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

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

C. Financial Hardship Policy.

(1) Subject to §D of regulation .05 of this chapter, the financial assistance policy required under §A of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland, shall provide reduced-cost medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

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

- *(a) Shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received; and*
- *(b) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost medically necessary care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost medically necessary care.*

(3) If a patient is eligible for reduced-cost medically necessary care under a hospital's financial hardship policy, the hospital shall, at a minimum, reduce the patient's out-of-pocket expenses for hospital services:

- *(a) For a patient with family income of at least 201 percent but not more than 250 percent of the federal poverty level, by 75 percent;*
- *(b) For a patient with family income of more than 250 percent but not more than 300 percent of the federal poverty level, by 60 percent;*
- *(c) For a patient with family income of more than 300 percent but not more than 350 percent of the federal poverty level, by 50 percent;*
- *(d) For a patient with family income of more than 350 percent but not more than 400 percent of the federal poverty level, by 45 percent;*
- *(e) For a patient with family income of more than 400 percent but not more than 450 percent of the federal poverty level, by 40 percent;*
- *(f) For a patient with family income of more than 450 percent but not more than 500 percent of the federal poverty level, by 35.*

D. The Commission may, by regulation, establish income thresholds higher than those in section .06 of this chapter, taking into account the hospital's:

(a) Patient mix;

(b)Financial condition;

(c)Level of bad debt experienced;

(d) Amount of financial assistance provided; and

(e)Other relevant factors.

E.

(1) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(2) If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection (such as a debt collector or eligibility vendor), that vendor shall post a notice in a conspicuous place on their website or online payment portal, informing patients of their right to apply for financial assistance, providing a link to the financial assistance application, and providing information on how to submit the application. Placement on the website or online payment portal should be based on the best interest of the patient.

F. The notice required under §E of this regulation shall be in:

(1) Simplified language in at least 10-point type; and

(2) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

G. Each hospital shall use a Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost medically necessary care.

H. Each hospital shall use a Financial Assistance Application that meets the requirements of this regulation and is consistent with the Uniform Financial Assistance Application.

I. Each hospital shall establish a mechanism to provide a Financial Assistance Application to patients regardless of their insurance status. A hospital may require from patients or their guardians only those documents required to validate the information provided on the application.

J. Asset Test Requirements. A hospital may utilize an asset test when determining eligibility for financial assistance. If it does so, "income" under this section includes household monetary assets.

.07. One Process for Financial Assistance and Payment Plans.

Hospitals shall use the same process for establishing eligibility for financial assistance under section .06 under this regulation as they do to establish the 5% monthly payment threshold for payment plans under section .05F. of this regulation.

.08 Patient Complaints.

The Commission shall post a process on its website for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of Health-General Article, §19-214.1 or 19-214.2, Annotated Code of Maryland. The process established shall include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit. The process shall conform to the requirements of Health-General Article, §19-214.3, Annotated Code of Maryland.

.09 Hospital Written Estimate.

- *A. In addition to the good faith estimate requirements in PHS Act Sec. 2799B-6, the No Surprises Act, on request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.*
- *B. The written estimate shall state clearly that it is only an estimate and actual charges could vary.*
- *C. A hospital may restrict the availability of a written estimate to normal business office hours.*
- *D. The provisions set forth in §A—C of this section do not apply to emergency services.*

.10 Other Obligations.

This chapter does not diminish any obligations of a debt collector, as defined by under COMAR 10.37.13.01, under other applicable laws or regulations, including, without limitation, any requirement for the debt collector to obtain a collection agency license from the State Collection Agency Licensing Board in accordance with Business Regulation Article, Title 7, subtitle 3 Annotated Code of Maryland.

JOSHUA SHARFSTEIN

Chair

Health Services Cost Review Commission