Discussion Document, HSCRC Workgroup on Hospital Refunds

August 15, 2022

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Legal Requirement

Chapter 683 (2022) requires the Health Services Cost Review Commission (HSCRC) to submit a report on the development and implementation by hospitals of the statutorily required process for refunding amounts paid by certain patients eligible for free care.[1] Chapter 683 (2022) requires HSCRC, in coordination with the Department of Human Services (DHS), the State-designated exchange (CRISP), the Office of the Comptroller, and the Maryland Hospital Association (MHA), to develop a process that:

1. Identifies patients who paid for hospitals services who may have qualified for free care under Health General §19–214.1 at the time of care during calendar years 2017 through 2021;

[1] Each hospital in Maryland is required by law to provide free care to patients at specified income levels under Health General §19-214.1. This requirement first went into effect in 2005 and has changed several times since that date.

2. Provides reimbursement to the identified patients, which may be applied incrementally.
3. Ensures that a patient's alternate address is used if the patient requested an alternate address for safety reasons; and
4. Determines how HSCRC, DHS, and the Office of the Comptroller should share and disclose relevant information, including tax information, to the minimum extent necessary to the hospital and in accordance with federal and state confidentiality laws for the purpose of carrying out the required process.

Under the statute, HSCRC is allowed to alter the process that is developed under Chapter 683 as necessary.

Key Dates

CH 683 contains several key dates, including a report required on January 1, 2023. To develop the process required by CH 683, HSCRC began engaging key stakeholders in the spring of 2022. The workgroup on August 15th is the first opportunity for all the stakeholders named in the statute to come together to discuss possible processes for providing refunds to patients as required by the legislation.

- **April/May 2022 (completed):** HSCRC met with DHS, CRISP, the Comptroller's Office, and a representative of domestic violence advocates (Robyn Elliot of Policy Partners) to collect feedback on a possible process, iterating on the process that was described in the introduced version of HB 694 (2022). HSCRC provided a discussion document, including the revised process, to MHA.
- **June/July 2022 (completed):** MHA reviewed the revised process with their members and provided feedback to HSCRC.
- **August/October 2022:**
    - HSCRC engaged AAGs on legal questions related to data privacy and other issues.
    - HSCRC is convening a workgroup including all the organizations listed above to discuss the potential process.
- **October 2022- December 2022**:
    - HSCRC drafts report required by Ch. 683 (2022). Deadline 1/1/23.
    - HSCRC drafts legislation as an appendix to the report.
- **January 2023 – April 2023**
    - The legislature considers legislation, if appropriate
    - If an acceptable process is identified, HSCRC clarifies the process with hospitals for implementation
- **Summer 2023:** Hospitals begin implementation (assuming legislation passes).
- **October 2023- December 2023**: HSCRC drafts report required by Ch. 683 (2022). Deadline 1/1/24.
- **June 30, 2025**: Ch. 683 (2022) is abrogated.

Workgroup Discussion Questions for August 15, 2022, Workgroup Meeting

1. **Process:** The introduced version of Ch. 683 (2022) contained a process for providing refunds to individuals. HSCRC used the process in the bill to develop "Exhibit 1: Data Flow based on Introduced Version of HB 694". HSCRC has developed two alternative

processes, “Exhibit 2: Alternative Data Flow to implement HB 694, start w/ hospital data”, and “Exhibit 3: Alternative Data Flow to implement HB 694, start w/ HSCRC data”. Details of these processes, for discussion, are in Appendixes B-D. Other processes are possible.

a. Does each process meet the requirements of CH 683?
    i. Identifies patients who paid & may have qualified for free care (2017 through 2021)
    ii. Provides reimbursement to the identified patients, which may be applied incrementally
    iii. Patient’s alternate/safe address is used
    iv. Determines how HSCRC, DHS, and the Office of the Comptroller should share and disclose relevant information, to the minimum extent necessary to the hospital and in accordance with federal and state confidentiality laws for the purpose of carrying out the required process.
        1. Is the process legally feasible now?
        2. What legal issues can be solved with a state statute?
        3. What legal issues would remain after a new state law?
b. Is the process optional operationally feasible? Why or why not?
c. Are there other benefits or concerns about this process that should be considered?

Workgroup Items for Written Comment after August 15, 2022

2. **Items discussed in the meeting:** Workgroup members may provide feedback on any items listed for discussion above.
3. **Data fields for matching data sets:** What are the minimal data fields that are needed to allow for reasonable matching rates between data sets?
    a. **Address for data matching:** Is the address that was on the file at the date of service or tax/program year the best for matching data (vs. The most current address on file)?
4. **Alternative address:** Ch. 683 requires that the refund process ensures “that a patient’s alternate address is used if the patient requested an alternate address for safety reasons”. It does not appear that hospitals have a uniform way of flagging safe addresses. However, HSCRC believes that using the mailing addresses on file with the hospitals (as opposed to addresses from the Comptroller’s office or DHS) is the best way to meet this requirement.
    a. Does the workgroup agree?
    b. What should hospitals do if they have multiple addresses?
    c. How should the hospitals handle similar issues (ex. Teens who have opted out of mail and prefer email or phone)
5. **Undeliverable addresses:**
    a. If a letter (if used) or refund check is returned as “undeliverable” is any additional action required?

b. **Reporting**: Can the entities sending letters (if used) track returned mail to track the number of returned letters? Can hospitals track returned checks to report the number of returned checks?

6. **Age of address:** Should the entity supplying the address for the mailing (if any) use the address associated with the year of the date of service or the most recent address available?
7. **Electronic Delivery:** If a patient has opted out of snail mail from the hospital, should the patient be notified electronically?
8. Any other comments are welcome.

Workgroup Discussion Questions for Future Workgroup Meetings

9. **End of process:** When has a hospital done "enough" under this process, so that their full obligation to provide refunds is complete?
10. **Letters:**
    a. **Branding:** If the final process requires that a state agency send letters to patients, how should those letters be branded so that the mailing looks valid to recipients? Options include:
        i. the Office of the Comptroller and DHS, respectively
        ii. HSCRC
            1. Pro: HSCRC knows the policy
            2. Con: HSCRC is not a known entity to consumers and independent branding may mean that consumers do not recognize it as a state agency.
        iii. HEAU
    b. **Authentication:** How will hospitals know that the letters are valid, particularly if they serve as de facto evidence of income or program enrollment? Should there be some sort of serial number or other authentication method? What support would the Comptroller's Office and DHS provide to hospitals to verify letters? A hospital would still need to use their own data to verify how much the patient paid out of pocket and if an asset test was applied. Hospitals are concerned about fraudulent letters.
    c. **Providing letters to hospitals:** What methods are acceptable for patients to use to provide the letter to the hospital? Does this need to be specified in the process? For example, is an emailed picture of the letter ok, so that the patient doesn't have to come to the hospital?
    d. **Message for letters:** "Our records indicate that you may have paid for care at (hospital's name) in (year), may have been eligible for free care, and may be entitled to a refund. To apply for a potential refund, go to (hospital's website) or call (hospital's phone number)." If letters are used, more complete sample text will be available for feedback at a later date.
11. **State Government patient support:**
    a. Who should the patient's go to in state government if they have questions about this process (website, email, phone)? Options:
        i. the Office of the Comptroller and DHS, respectively.
        ii. HSCRC

iii. HEAU

b. Does the agency have the staff/expertise/resources to field these inquiries?

12. **Timing of implementation:** Should the implementation of the process under Ch. 683 be incremental, so that one or two years of refunds are completed at a time, or should the process for all years be completed at once?
    i. **Pilot & process adjustment:** Should one year be done as a pilot and the process possibly adjusted based on that experience before the other years are completed?
    ii. **First year:** If the years are done separately, should the process start with refunds for 2017 (the oldest data) or 2021 (the newest data)?
13. **Deadlines:** It does not make sense to discuss deadlines for steps in the process until the process is decided on.
14. **Evidence of noncompliance:** Should the outcomes of this process be considered as evidence of noncompliance for application of HG 19-214.3 (which changed significantly in 2020, part way through this period) or the Consumer Protection Act?
15. **Medicare patients and other patient populations with no known income.** In the analysis for the report required by Ch. 470 (2020) HSCRC made assumptions for patient visits for which no patient income information was available (about 43% of total patient visits in a year). Medicare patients make up almost all of this group of patient visits. Based on national data, HSCRC estimated that 20% of these patients had incomes under 200% FPL and that the average refund per individual patient would be approximately $300 for the 2-year period (2017-2018). Depending on the process selected, should data for all Medicare beneficiaries with a patient visit in a year that do not have matching comptroller data be shared with DHS for program matching? It is likely that less than 20% of Medicare beneficiaries would ultimately match with a DHS program, as it is unlikely that qualified Medicare beneficiaries are fully enrolled in DHS programs. This is a data privacy concern for Medicare beneficiaries, the vast majority of whom will not benefit from this data exchange.

Table: HSCRC estimates of the number of Patient Visits for MD Residents w. Medicare as a player and no income data from the Comptroller's office that may have qualified for free care and may have paid a hospital bill out of pocket.

	Total Patient Visits		Unique Patient Visits per Hospital across both Years	Estimated OOP per Unique Patient across both Years
	CY17	***CY18***	***CY17&18***	***CY17&18***
Total	310,000	270,000	100,000	$300

Elements of the Process that (hopefully) do not require workgroup discussion:

1. **Out-of-pocket payments:** Refunds are for amounts paid directly by the patient (or guarantor) (i.e., out-of-pocket payments), not for amounts covered by an insurer (whether paid directly to the hospital or to the patient).

2. **Date of service:** The process applies to hospital services that were provided to the patient from January 1, 2017, through December 31, 2021, regardless of when the bill was sent or when the bill was paid.
3. **Family income:** Income eligibility for free care is based on family income (Health General §19-214.1) not individual income.
4. **De Facto evidence of income:** For purposes of Ch. 683, a letter from the Comptroller's office or dataset from the Comptroller's Office shall be treated by the hospital as de facto evidence of the patient's eligibility for free care based on income.
5. **De Facto evidence of presumptive eligibility:** For purposes of Ch. 683, a letter from the DHS or dataset from DHS shall be treated by the hospital as de facto evidence of the patient's eligibility for free care based on enrollment in SNAP or the Low-Income Energy Assistance, which qualify for free care based on presumptive eligibility.
6. **Letters, not postcards:** If "letters" are used, they must be in sealed envelopes, not postcards.
7. **Hospital patient support:** Hospitals should each create a webpage that provides information on refunds for patients identified through this process that includes information about the process and the appropriate email address and phone number to contact the appropriate office about the refund.
8. **Reimbursement of State agencies:** Hospitals shall reimburse the State agencies involved in this process for the costs incurred through this process. The reimbursement shall be based on the hospital's proportion of the total number of patients who were identified by the state agencies as potentially eligible for refunds in a designated year, as determined by the Commission.
9. **Data Destruction:** All data stored and exchanged under this process is destroyed when it is no longer needed to implement the process. A future meeting may be required to specify the timing for that data destruction.
10. **DUAs and MOUs**- All entities involved in transferring data will need appropriate DUA agreements (and MOUs, if applicable).
11. **Summary data will be reported to HSCRC:** The data listed in Appendix E (altered as necessary based on the final process for implementing Ch. 683) will be reported to HSCRC for subsequent reports to the legislature.
12. **FPL Level.** The eligibility standard for free hospital care under COMAR 10.37.10.26 A-2 was "at or below 200%" FPL for the whole period of 2017-2021 and this FPL will be used for purposes of CH 683. Changes were made to COMAR 10.37.10.26 in 2012, 2014, 2019 and 2021. In all of those versions 10.37.10.26A-2(2) contained virtually the same language. Therefore, the FPL percentage requirements in that reg have been the same since at least 2012.
13. **Presumptive Eligibility:** The same presumptive eligibility language that is currently in COMAR 10.37.10.26A-2(2)(c) was in these regulations in 2017. Thus, the presumptive eligibility policy applies for the whole period covered by Ch. 683.
14. **Asset tests.** The same asset test language that is currently in COMAR 10.37.10.26A-2(2)(c) was in these regulations in 2017. Thus, the asset test regulations apply for the whole period covered by Ch. 683. Hospitals had discretion to adopt asset test policies as a component of their financial assistance policies over this time period. Hospitals

may apply the asset test policy that they had in effect on the date of service or may apply their current asset test policy if it is more beneficial to the patient. This choice is at the discretion of the hospital but should be applied consistently by the hospital throughout the implementation of Ch. 683.

15. **No $25 minimum:** HSCRC believes that Ch. 683, which does not include a limit on the refund amount, supersedes COMAR 10.37.10.26A-2(3)(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;"). Thus, there is no minimum refund under Ch. 683.
16. **Hospital Services Only:** Ch. 683 only applies to hospital services that are subject to regulation by HSCRC. Ch. 683 does not apply to physician services or other unregulated services.
17. **Relationship between date of service and tax data/program enrollment data.** Potential eligibility for financial assistance will be based on the tax data or DHS program enrollment data for the same year as the date of service identified in the hospital or HSCRC data. Tax data or program enrollment data from another year than the date of service will not be used.
18. **No changes in rates:** HSCRC will not adjust hospital rates based on refunds or other costs to hospitals incurred because of Ch. 683 (2022).
19. **Summary data will be reported to HSCRC**. See appendix E.

Considerations for the workgroup and legislators (for report):

1. **Data security:** The more often data is transferred and the entities that have access to data, the more likely it is that a data breach occurs.

Potential Recommendations to the Legislature (for report):

1. **Legislation is required:** To implement a process as required by Ch. 683, additional legislation is required. This legislation should contain the following elements:
    a. **Authorization of data transfer:** Explicit and narrowly tailored authorization for all data transfers required by the refund process.
        i. **HIPAA compliance:** Explicit statutory requirements regarding the data sharing required by the process will help with HIPAA compliance (*note that this recommendation is pending additional AAG comments).*
        ii. **DHS data sharing:** A legislative change to HS 1-201 to add data sharing under HG 214.4 as a reason that DHS can share data.
        iii. **Comptroller Data sharing:** A legislative change is preferred. *Comptroller's Office- can you please provide more information about the statutory changes that you think would be necessary?*
    b. **Data Security:** An explicit requirement that all entities exchanging data under the process (except for patients) shall enter DUAs that cover all required data exchanges. The DUAs shall ensure compliance with all relevant State and federal confidentiality laws, the security of data during transfer and during storage and use, shall **limit the use** of data to the refund process only, and shall require **destruction** of all transferred data once the use of that data for the

process required by Ch. 683 is complete. The legislation should clarify who is responsible for the data if a breach occurs.

c. **De Facto evidence of income and/or program enrollment:** HSCRC recommends that HB 694 state clearly that the patient's annual income, if known from tax data, is treated as the patient's income for the purposes of determining whether the patient was eligible for free care for that year under this bill.

Appendix A: Legal Questions shared with AAGs

HSCRC's AAGs are working with other AAGs in MDH, DHS, and the Comptroller's Office and will provide feedback on these questions at a later date.

1. **For the Comptroller's Office:** The Comptroller's Office has expressed that they prefer not to share tax data (including FPL range) for taxpayers with non-government entities (e.g., hospitals). Is there a statutory or regulatory citation for this policy? Can this be cured by a change to statute?
2. **Privacy laws:** Would any entity sharing the data required under any of the processes violate HIPAA, 42 CFR Part 2 (for behavioral health and substance abuse treatment services), or other relevant laws or regulations?
    a. HIPAA allows disclosure "required by law" which could include state statute (i.e., some of the legal privacy issues may be solved by passing a statute explicitly allowing the data disclosure).
    b. HIPAA also allows disclosure to a health oversight agency (i.e., HSCRC) for certain purposes (45 CFR 164.502(j)(1)(ii)(A))
    c. 42 CFR part 2 isn't as generous with disclosure as with HIPAA. Disclosure of these cases are restricted to audits, court orders, criminal proceedings and for treatment.
    d. Additional input on this question will be provided by the AAGs
3. **Pilot:** Do you think the Ch. 683 allows for a "pilot" using data for 1 year, followed by a possible revision to the refund process before the other years are completed?
4. **De Facto evidence of income/program enrollment.** If I want to treat the following information as de facto evidence for purposes of this bill, does that need to be explicit in legislation, or do we have the authority to do that as staff?
    a. **De Facto evidence of income:** For purposes of Ch. 683, a letter from the Comptroller's office or dataset from the Comptroller's Office shall be treated by the hospital as de facto evidence of the patient's eligibility for free care based on income.
    b. **De Facto evidence of presumptive eligibility:** For purposes of Ch. 683, a letter from the DHS or dataset from DHS shall be treated by the hospital as de facto evidence of the patient's eligibility for free care based on enrollment in SNAP or the Low-Income Energy Assistance, which qualify for free care based on presumptive eligibility.
5. **Data Breach:** This process will require substantial sharing of PII between state agencies and possibly non-governmental entities such as CRISP and the hospitals. If a data breach occurs with data transferred or stored because of Ch. 683, does the law already provide clarity about who informs consumers about such a breach, or is additional statutory language necessary? Hospitals have asked for clarity that the state agencies take responsibility for any hospital data they possess.

Appendix B: Proposed Process based on Introduced Version of HB 694; starts w/ Comptroller Data

Step	Notes and Questions
1. **Comptroller shares data with CRISP:** a. 2017-2018: The Office of the Comptroller sent tax year data to CRISP (completed). b. 2019-2021: The Office of the Comptroller would only share data for individuals at or below 200% FPL.	The process is different for 2019-2020 because only patients with incomes at or below 200% FPL are relevant for the refund process. Limiting the data to at or below 200% FPL is meant to limit the sharing of tax data to that data that is strictly needed for the refund process. However, this limitation in step 1 contributes to more patient data being shared in step 4, below. **Concerns**: ● **Data Privacy:** The majority of taxpayers likely did not have a hospital visit in any year. Thus, this is sharing taxpayer data for an unintended use with little likely benefit for each taxpayer. **Questions for the AAG:** Would additional state legislation be needed to allow this transfer of data? Note that the transfer of data for 2017-2018 occurred under the authority of HB 1420(2020). Are there prohibitions that cannot be overcome with state legislation? **Question for the CRISP**: What are the minimal data elements that would be required for data matching?
2. CRISP matches data: CRISP matches the data from the Comptroller's Office to data in the CRISP master patient index. For data that matches, CRISP creates a data set that includes only the	**Concern:** The matching process will likely be imperfect (i.e., some people who were enrolled in these programs may not match, and

individuals that had a match.	some people who were not enrolled may match).
3. CRISP Data is shared w/ HSCRC **a. 2017-2018:** CRISP shared a crosswalk of CRISP EIDs and Comptroller UIDs for patients that matched with the comptroller's office. The Comptroller's office added income ranges and sent a data set to HSCRC that included the CRISP EID and the income range only. **b. 2019-2021-** CRISP sends CRISP EID's that match the Office of the Comptroller's list of individuals at or below 200% FPL to HSCRC. Income range data is not needed. CRISP destroys the data sent by the Comptroller's Office in step 1 after the Comptroller and HSCRC receive the data sets in this step.	
4. HSCRC IDs Patients who may have paid a bill. HSCRC uses case-mix and write-off data to identify patients who may have paid a hospital bill for a data of service in a year. ● HSCRC uses the CRISP IDs to identify people who may have had a bill that had an income at or below 200% FPL and sends those CRISP EIDs, hospital name, and date of service to the Comptroller. ● HSCRC creates another data set that includes all individuals who may have paid a bill but did not have CRISP EID indicating an income at or below 200% FPL. HSCRC sends the CRISP EIDS, hospital name, and data of service to CRISP.	HSCRC has CRISP IDs for patients but does not have key identifiable information (address, phone, etc.). Thus, HSCRC must rely on CRISP for matching those IDs to identifiable information. ● For 2017-2018, the "no known income" file excludes all people with an income that is known to the comptroller, so that patients w/ known incomes over 200% FPL do not have their data shared beyond this step. 43% of individuals that HSCRC modeled as being potentially eligible for free care did not have known income data from the Comptroller's office.

	● For 2019-2021, if, in step 1, the data shared by the comptroller is limited to patients at or under 200% FPL, the "no known income" file will include a large number of people with incomes that are over 200% and are known to the Comptroller. This will result in sharing more individuals' information w/ CRISP when it is highly unlikely that they will match with a DHS program. This is a privacy concern.
5. Comptroller reidentifies data for at/under 200% FPL who may have paid a bill. The Comptroller uses the CRISP EID in the data from HSCRC and the Crosswalk from CRISP to identify taxpayers under 200% FPL who may have paid a hospital bill. The Comptroller creates a data set that includes the patient's name, tax address, hospital name and year of service.	
6. Option A: **Comptroller Sends Letters:** The Comptroller uses tax addresses to send letters to patients in the data set of hospital data that matched tax data with a qualifying FPL.	**Question for the Comptroller:** Does the Comptroller need statutory language to send these letters? **Concern:** The tax address is not a "safe" address and is not related to what the patient may have asked the hospital to do with mailings or electronic materials.

6. *Option B:* Comptroller dataset shared with hospitals: The Comptroller sends data for patients with a qualifying FPL to each hospital. Only data for that hospital is shared with each hospital.	**Benefit:** The hospital can use the best address they have on file (including a safe address if they have one). **Concerns**: This option results in the Comptroller sharing tax information with the hospitals (i.e., whether a patient has a qualifying FPL). **Question for the Comptroller:** Does the Comptroller need statutory language to share this data?
7. DHS sends data to CRISP. DHS sends data for all enrollees in SNAP and the Low-Income Energy Assistance Program (the two DHS programs that qualify for hospital free care presumptive eligibility) for each year to CRISP for matching.	**Purpose:** The purpose of this step is to identify individuals who may have been eligible for free care under presumptive eligibility rules under COMAR 10.37.10.26 A-2, which provides presumptive eligibility for free care to people enrolled in the following programs: Households with children in the free or reduced lunch program; Supplemental Nutritional Assistance Program (SNAP); Low-income-household energy assistance program; Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package; Women, Infants and Children (WIC) **Questions for CRISP:** What are the minimal data elements that would be required for data matching? **Concerns**: ● Only SNAP and Energy Assistance are DHS programs. This means that people who were enrolled in free lunch, PAC, or WIC will not be identified through this process. ○ Free and Reduced lunch is a US Department of Agriculture (USDA) program administered by Local Education Agencies (LEAs). ○ PAC no longer exists. ○ WIC is administered by the Maryland Department of

	Health. ● The matching process will likely be imperfect (i.e., some people who were enrolled in DHS programs may not match, and some people who were not enrolled may match)
8. CRISP matches data from DHS and HSCRC: CRISP matches the data from DHS to CRISP EIDs and then matches those CRISP EIDS with HSCRC's list of patients who may have paid for a bill and who are not under 200% (patients for whom HSCRC doesn't know an income). Program enrollment year is matched to the year of the hospital date of service. For the data that matches, CRISP creates a data set that includes DHS ID, hospital name, and date of service and shares that data with DHS. This data is sent to DHS. **Data that does not match is destroyed.**	This narrows the data set down to people in DHS programs that are eligible for free care through presumptive eligibility.
9. DHS reidentifies the data from CRISP. DHS matches the DHS user ID in the data sent from CRISP, identifying patients who may have paid a bill and who were in a DHS program in the year they got the paid hospital service, to their program data to create a data set with name, DHS address,	
10a. *Option A:* DHS Sends Letters: DHS uses DHS addresses to send letters to patients in the data set of hospital data that matched to the DHS programs	**Question for the DHS:** Does DHS need statutory language to send these letters? **Concern:** The DHS address may not be a "safe" address and is not related to what the patient may have asked the hospital to do with mailings or electronic materials.
10b. *Option B:* DHS dataset shared with hospitals: DHS sends	**Benefit:** The hospital can use the best address they have on file

data for patients to each hospital from the hospital data that matched to the DHS programs. Only data for that hospital is shared with each hospital.	(including a safe address if they have one). **Concern**: This option results in DHS sharing DHS and hospital discharge information with the hospitals (whether the person was enrolled in a program). **Question for DHS:** Does DHS need statutory language to share this data?
11. If letters are used, **patients provide the letter** from the comptroller or DHS to the hospital.	
12. The **hospital** determines if an individual was eligible for free care and that the patient was not disqualified from free care due to the use of an asset test under HG 19-214.1(b)(8). The hospital shall determine the amount the patient paid, if any. The hospital **provides a refund** to those who overpaid. The hospital is not required to provide refunds under $25.	
13. All entities w/ remaining data from the process destroy that data	

Appendix C: Alternative Proposed Process (Option 2); Starts w/ Hospital Data

Step	Notes and Questions
1. Hospitals share data of patients who paid: Hospitals share the identity of all individuals who had a visit in 2017-2021 and paid for care out of pocket with the Comptroller's office via secure transfer. This should only be patients with a Maryland address (not out of state). The data set will contain: Patient Full Name, Address (if a safe address is available, include the safe address), Date of Birth, Gender, Social Security Number (when available) and Phone Number (when available), [OTHER?], Date(s) of service (only for services for which the patient paid an out-of-pocket amount), Hospital Name.	**Benefit of this approach:** The initial data set is limited to patients who had a date of service in the relevant time period and paid an amount out-of-pocket for that service, as opposed to all taxpayers (as in the original process). The majority of taxpayers likely did not have a hospital visit in any year. This approach ensures that DHS and the Comptroller have the address that the patient provided to the hospital, which is more likely to be a safe address than the DHS or Tax addresses. **Concerns**: ● **Data Privacy:** ○ A trusted health provider is sharing identifiable information with the Comptroller's office, (and for some patients, DHS) of individuals, including individuals who have provided a safe address to the provider without that person's consent. ○ A trusted health provider is sharing information for all patients with a state agency. The majority of these patients will not be eligible for free care or a refund under Ch. 683. ○ For consumers, this is an unanticipated use of their information. Statutory/regulatory restrictions from HIPAA and 42 CFR Part 2 may prevent this data sharing. ● **Volume of data:** Hospitals have millions of encounters a year. This step will require transfer and analysis of very large files. ● **Staffing:** According to hospitals, 1 in 5 hospital positions is vacant. This data transfer would require significant work,

	particularly if systems changed between the start of 2017 and now which would strain staff. **Questions for the AAG:** Could this data legally be transferred from hospitals to the Comptroller's office under current law or is it prohibited by HIPAA or another law? *Hospitals are concerned that sharing this data would violate section 164.512(a) (I assume this is HIPAA), which permits hospitals to disclose protected health information to the extent required by law and that the use or disclosure complies with and is limited to the relevant requirements of the law. Hospitals feel that this data transfer is overbroad to meet the requirements of Ch. 683.* Would additional state legislation be needed to allow this transfer of data? Are there prohibitions that cannot be overcome with state legislation? Do certain populations (ex. 42 CFR part 2) need to be excluded from this data set? **Questions for the Comptroller**: What are the minimal data elements that would be required for data matching? Can the Comptroller's infrastructure handle the volume of data in these files? **Question for DHS:** What are the minimal data elements that would be required for data matching with your program data?
2. Comptroller Matches Data: The Comptroller's Office will match the hospital data to their data and creates the	**Question for the Comptroller:** How long will this step take?

following data sets: **a. Known income at or under FPL:** a data set with patients who paid OOP costs for a date of service in the year and a known income that is at or under the FPL limit for free hospital care for that year. This data set contains, at a minimum: Name, address, hospital name, hospital year of service. **b. No known income:** a data set with patients who paid OOP costs for a date of service in a year and the Comptroller does not know that patient's income in that year. This data set contains: Patient Full Name, Mailing Address (from the hospital), Date of Birth, Gender, Social Security Number (when available) and Phone Number (when available), [OTHER?], Date(s) of service (only for services for which the patient paid an out-of-pocket amount), Hospital Name. **c. Known income above FPL:** The Comptroller will **destroy the data r**eceived from the hospitals for patients with a known income over the FPL limit for free care as that data is not required for the rest of the refund process.	**Concern:** The matching process will likely be imperfect (i.e., some people who were in the hospital and tax data sets may not match, and there may be some false matches, like for people with similar names).

3. Comptroller sends hospital data for individuals with no known income to DHS: The Comptroller's Office will send the hospital data that does not match to the Comptroller's data set to DHS via secure transfer. *These are individuals who paid for hospital visits and who have no known income.*	**Question for the Comptroller:** Does the comptroller need statutory language to share this data? **Privacy Concern:** This data could include many people who have no relationship with DHS, including people who would be surprised to know that DHS has their data and people who may not want DHS to have their data (e.g., stigma re: social services). For consumers, this is an unanticipated use of their information. These patients likely do not expect that their patient data will be shared with DHS by their hospital.
4. DHS matches the hospital data forwarded by the Comptroller's Office **to enrollees** in SNAP and Energy Assistance (2 programs that qualify for hospital free care presumptive eligibility) in the year of the hospital date of service. **Data that does not match is destroyed.**	**Purpose:** The purpose of this step is to identify individuals who may have been eligible for free care under presumptive eligibility rules under COMAR 10.37.10.26 A-2, which provides presumptive eligibility for free care to people enrolled in the following programs: Households with children in the free or reduced lunch program; Supplemental Nutritional Assistance Program (SNAP); Low-income-household energy assistance program; Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package; Women, Infants and Children (WIC) **Concerns**: ● Only SNAP and Energy Assistance are DHS programs. This means that people who were enrolled in free lunch, PAC, or WIC will not be identified through this process. ○ Free and Reduced lunch is a US Department of Agriculture (USDA) program administered by Local Education Agencies (LEAs). ○ PAC no longer exists. ○ WIC is administered by the Maryland Department of Health.

	● The matching process will likely be imperfect (i.e., some people who were enrolled in DHS programs may not match, and some people who were not enrolled may match)
5. *Option A:* DHS Sends Letters: DHS uses DHS addresses **OR** the hospital addresses to send letters to patients in the data set of hospital data that matched to the DHS programs	**Question for the DHS:** Does DHS need statutory language to send these letters? **Concern:** The DHS address may not be a "safe" address and is not related to what the patient may have asked the hospital to do with mailings or electronic materials.
5. *Option B:* DHS dataset shared with hospitals: DHS sends data for patients to each hospital from the hospital data that matched to the DHS programs. Only data for that hospital is shared with each hospital.	**Benefit:** The hospital can use the best address they have on file (including a safe address if they have one). **Concern**: This option results in DHS sharing DHS (i.e., whether the person was enrolled in a DHS program) and hospital discharge information with the hospitals. **Question for DHS:** Does DHS need statutory language to share this data?
***6. Option A:* Comptroller Sends Letters:** The Comptroller uses tax addresses **OR** the hospital addresses to send letters to patients in the data set of hospital data that matched tax data with a qualifying FPL.	**Question for the Comptroller:** Does the Comptroller need statutory language to send these letters? **Concern:** ● The tax address is not a "safe" address and is not related to what the patient may have asked the hospital to do with mailings or electronic materials. ● The Comptroller was concerned about sending tax info (the fact of an under 200% FPL income) to a non-tax address if the hospital address was used. Can this be solved through a statutory change?

6. *Option B:* Comptroller dataset shared with hospitals: The Comptroller sends data for patients with a qualifying FPL to each hospital. Only data for that hospital is shared with each hospital.	**Benefit:** The hospital can use the best address they have on file (including a safe address if they have one). **Concern**: This option results in the Comptroller sharing tax information with the hospitals (i.e., whether a patient has a qualifying FPL). **Question for the Comptroller:** Does the Comptroller need statutory language to share this data?
7. If letters are used, **patients provide the letter** from the comptroller or DHS to the hospital.	
8. The **hospital** determines if an individual was eligible for free care and that the patient was not disqualified from free care due to the use of an asset test under HG 19-214.1(b)(8). The hospital shall determine the amount the patient paid, if any. The hospital **provides a refund** to those who overpaid. The hospital is not required to provide refunds under $25.	
9. All entities w/ remaining data from the process destroy that data	

Appendix D: Alternative Proposed Process (Option 3); Starts w/ HSCRC Data

Step	Notes and Questions
1. HSCRC IDs Patients who may have paid a bill. HSCRC uses case-mix and write-off data to identify patients who may have paid a hospital bill for a date of service in a year. HSCRC sends those CRISP EIDs, hospital name, and date of service to CRISP for these patients.	**Benefit of this approach:** The initial data set is limited to patients who had a date of service in the relevant time period and may have paid an amount out-of-pocket for that service, as opposed to all taxpayers (as in the original process).
2. CRISP adds identifiable information: CRISP adds identifiable info (Name, address, etc.) for matching to the HSCRC data on patients who may have paid a bill	**Concerns**: ● **Data Privacy:** ○ HSCRC and CRISP are sharing information obtained from trusted health providers with the Comptroller and DHS without the patient's consent. ○ HSCRC's ability to identify who paid a bill is limited and HSCRC has no data to determine who may have been eligible for financial assistance. This will result in data being shared for individuals who are not eligible for a refund. **Questions for the AAG:** Would additional state legislation be needed to allow this transfer of data? Are there prohibitions that cannot be overcome with state legislation? Do certain populations (ex. 42 CFR part 2) need to be excluded from this data set?

	Question for CRISP: What legal barriers exist to sharing this data with the Comptroller, if any? **Questions for the Comptroller**: What are the minimal data elements that would be required for data matching? **Question for DHS:** What are the minimal data elements that would be required for data matching with your program data?
3. Comptroller Matches Data: The Comptroller's Office will match the HSCRC data to their data and create the following data sets: **d. Known income at or under 200% FPL:** a data set with patients who paid OOP costs for a date of service in the year and a known income that is at or under the FPL limit for free hospital care for that year. This data set contains, at a minimum: Name, address, hospital name, hospital year of service. **e. No known income:** a data set with patients who paid OOP costs for a date of service in a year and the Comptroller does not know that patient's income in that year. This data set contains: Patient Full Name, Mailing Address (from the hospital), Date of Birth, Gender, Social Security Number (when available) and Phone Number (when available), [OTHER?], Hospital Name, hospital year of service. **f. Known income above FPL:** The Comptroller will	**Question for the Comptroller:** How long will this step take? **Concern:** The matching process will likely be imperfect (i.e., some people who were in the hospital and tax data sets may not match, and there may be some false matches, like for people with similar names).

destroy the data received from the hospitals for patients with a known income over the FPL limit for free care as that data is not required for the rest of the refund process.	
4. Comptroller sends data for individuals with no known income to DHS: The Comptroller's Office will send the data that does not match to the Comptroller's data set to DHS via secure transfer. *These are individuals who likely paid for hospital visits and who have no known income.*	**Question for the Comptroller:** Does the comptroller need statutory language to share this data? **Privacy Concern:** This data could include many people who have no relationship with DHS, including people who would be surprised to know that DHS has their data and people who may not want DHS to have their data (e.g., stigma re: social services). For consumers, this is an unanticipated use of their information. These patients likely do not expect that their patient data will be shared with DHS.
5. DHS matches the data forwarded by the Comptroller's Office **to enrollees** in SNAP and Energy Assistance (2 programs that qualify for hospital free care presumptive eligibility) in the year of the hospital date of service. These patients likely paid for a hospital service and were eligible for presumptive eligibility for free care based on DHS program enrollment. **Data that does not match is destroyed.**	**Purpose:** The purpose of this step is to identify individuals who may have been eligible for free care under presumptive eligibility rules under COMAR 10.37.10.26 A-2, which provides presumptive eligibility for free care to people enrolled in the following programs: Households with children in the free or reduced lunch program; Supplemental Nutritional Assistance Program (SNAP); Low-income-household energy assistance program; Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package; Women, Infants and Children (WIC) **Concerns**: ● Only SNAP and Energy Assistance are DHS programs. This means that people who were enrolled in free lunch, PAC, or WIC will not be identified through this process. ○ Free and Reduced lunch is a US Department of Agriculture (USDA) program administered by Local

	Education Agencies (LEAs). ○ PAC no longer exists. ○ WIC is administered by the Maryland Department of Health. ● The matching process will likely be imperfect (i.e., some people who were enrolled in DHS programs may not match, and some people who were not enrolled may match)
6. *Option A:* DHS Sends Letters: DHS uses DHS addresses to send letters to patients that matched to the DHS programs.	**Question for the DHS:** Does DHS need statutory language to send these letters? **Concern:** The DHS address may not be a "safe" address and is not related to what the patient may have asked the hospital to do with mailings or electronic materials.
6. *Option B:* DHS dataset shared with hospitals: DHS sends data for patients to each hospital that matches the DHS programs. Only data for that hospital is shared with each hospital.	**Benefit:** The hospital can use the best address they have on file (including a safe address if they have one). **Concern**: This option results in DHS sharing DHS program information (i.e., whether the person was enrolled in a DHS program) and hospital discharge information with the hospitals. **Question for DHS:** Does DHS need statutory language to share this data?
***7. Option A:* Comptroller Sends Letters:** The Comptroller uses tax addresses to send letters to patients who likely paid for a hospital service and had an income under 200% FPL.	**Question for the Comptroller:** Does the Comptroller need statutory language to send these letters? **Concern:** The tax address is not a "safe" address and is not related to what the patient may have asked the hospital to do with mailings or electronic materials.

7. *Option B:* Comptroller data shared with hospitals: The Comptroller sends data for patients who likely paid for a hospital service and had an income under 200% FPL. Only data for that hospital is shared with each hospital.	**Benefit:** The hospital can use the best address they have on file (including a safe address if they have one). **Concern**: This option results in the Comptroller sharing tax information with the hospitals (i.e., whether a patient has a qualifying FPL). **Question for the Comptroller:** Does the Comptroller need statutory language to share this data?
8. If letters are used, **patients provide the letter** from the comptroller or DHS to the hospital.	
9. The **hospital** determines if an individual was eligible for free care and that the patient was not disqualified from free care due to the use of an asset test under HG 19-214.1(b)(8). The hospital shall determine the amount the patient paid, if any. The hospital **provides a refund** to those who overpaid. The hospital is not required to provide refunds under $25.	
10. All entities w/ remaining data from the process destroy that data	

Appendix E: Reporting Requirements

HSCRC is required to report on the implementation of this process in January 2023 and January 2024. It would be helpful to have the following information for that reporting. This list is based on the process in appendix B and would need to be redrafted if a different process is used.

1. **From the hospitals:**
    a. The # of people provided refunds as of the reporting deadline, by hospital.
    b. The total $ amount of refunds issued as of the reporting deadline, by hospital
2. **From the Comptroller:** This is all summary data.
    a. The # of people, by hospital, in the data sets submitted by the hospitals (people with a date of service in 2017-2021 who paid any amount out of pocket).
    b. The # of people from the hospitals' data set that matched to the Comptroller data set, by hospital
    c. The % of people from the hospitals' data set that matched to the Comptroller data set
    d. The # of people from the hospital's data set that were determined to be at or below 200% FPL in a year that a hospital service was provided, by hospital.
    e. The # of people from the hospital's data set that did not match to the Comptroller data set and were sent to DHS, by hospital
    f. The % of people from the hospital's data set that did not match to the Comptroller data set and were sent to DHS.
    g. The # of letters sent
    h. The # of letters that returned to sender as of the reporting deadline.
3. **From DHS**
    a. The # of people from the hospital's data set that did not match the comptroller's data set that matched an eligible DHS program in a year that a hospital service was provided, by hospital

Appendix F: Process used to create report required by HB 1420

2017-2018 Data Analysis Completed for HB 1420 (2020) Report

Subject to HB 1420 (2020), the Comptroller, CRISP, and HSCRC worked together in the following ways to create a data set of individuals with hospital visits in 2017 and 2018 (based on the current MOU SOW):

1. The Comptroller sent, via secure transfer, to CRISP a file containing select demographic information for all Maryland residents who submitted tax information in 2017 and 2018. The demographic information includes the Comptroller ID (UID- specific to this project), Full Name, Address, Date of Birth, Gender, Social Security Number (when available) and Phone Number (when available).

2. CRISP matched the Comptroller data to data for individuals in CRISP's Master Patient Index and added a unique identifier for each matched resident (the CRISP EID). Once the EID was assigned, the file was de-identified (all identifying demographic information was removed) and only the CRISP EID and the Comptroller UID were sent back to the Comptroller, via secure transfer.

3. The Comptroller added the resident's income range for 2017 and 2018 and sent, via secure transfer, the de-identified file containing the CRISP EID and the income range to HSCRC for analysis.

4. HSCRC matched the de-identified dataset with case mix data & write-off data (using the CRISP EID) and appended the income data. The HSCRC then analyzed the dataset to identify patients who may have paid a hospital bill when possibly eligible for free care for purposes of the report required under HB 1420.

Appendix G: HSCRC Estimates of Visits and Assumed Out-of-Pocket Payments and Data Limitations

The figures below are provided to give a sense of the scale of this project. These figures are derived from analysis that HSCRC completed for the report "Analysis of the impact of hospital financial assistance policy options on uncompensated care and costs to payers", as required by Ch. 470 (2020).

Table 1 shows the estimated number of hospital visits in CY 2017 and CY 2018 for patients that HSCRC estimates may have qualified for free care in a year and may have paid a bill out of pocket. There were approximately 700,000 hospital visits a year, representing about 300,000 unique patients over the two-year period (as some patients had more than one visit in a year). These figures include patients with Commercial insurance and/or Medicare Coverage. Approximately 45% of these visits had a known income that was at or below 200% FPL, based on data from the Comptroller's Office.

Table 1. Estimated # of hospital visits by patients who may have qualified for free care and may have paid a bill out of pocket.

	Total Patient Visits		Unique Patient Visits per Hospital across both Years
	CY17	***CY18***	***CY17&18***
Total	720,000	670,000	300,000
Visits with FPL at or below 200% FPL from Comptroller in the year of the patient visit	320,000	300,000	N/A
Visits with no income data for the year of the patient visit	390,000	370,000	140,000
Visits with no income data in the year of the patient visit, Medicare as a payer	310,000	270,000	100,000

For the other 55% of patients, no Comptroller income data was available for the year of the hospital visit. For about 12% of patient visits, HSCRC had data from the Comptroller for the other year showing an income at or below 200% FPL, but no income data for the year of the patient visit (for example, the patient visit occurred in 2017, but the Comptroller only had income data for 2018). 43% percent of the patient visits that HSCRC modeled as being eligible for free care for purposes of the report under Chapter 470 (2020) do not have income data from the Comptroller's Office for either 2017 or 2018. For these patients, HSCRC made assumptions about a patient's likely income for purposes of generating reasonable population-wide results.

Most of these patients were enrolled in Medicare. National statistics from the Kaiser Family Foundation demonstrate that about 20% of Medicare beneficiaries have incomes below 200% FPL. For purposes of the analysis under Chapter 470 (2020), staff randomly assigned an income of under 200% FPL to 20% of the Medicare population with no known income. This approach made sense for the purposes of population-level modeling of future policies required under Chapter 470 (2020). On the individual level, HSCRC staff do not know which patients in this population had incomes under 200% FPL. HSCRC also made assumptions about the income distribution of commercially insured individuals (4% - 5% of patient visits), and the homeless population (0.28% of the patient visits).

HSCRC made additional assumptions to calculate an assumed out-of-pocket payment that may have been paid by patients who may have qualified for free care. As noted in HSCRC's report from 2021, "this amounts to approximately $60 million statewide". HSCRC estimates that this amounts to about $400 per unique patient for the 2-year period of 2017-2018 combined. HSCRC expects that there is significant variation in the OOP amount by patient.

Table 2: Estimated out-of-pocket payments per unique patient who may have qualified for free care and may have paid a bill out of pocket for 2017 and 2018 combined.

	CY17&18
Total	$400
Patients with FPL at or below 200% FPL from Comptroller in the year of the patient visit	N/A (likely >$500)
Patients with no income data for the year of the patient visit	$300
Patients with no income data in the year of the patient visit, Medicare as a payer	$300

Data limitations for Income Data

HSCRC's modeling for the report under Chapter 470 (2020) relied on HSCRC's ability to determine the percent of the patients who likely paid for hospital visits in a year that they were eligible for free hospital care (i.e., under 200% FPL). HSCRC was able to verify federal poverty levels ranges for some patients using income range (tax) data from the Comptroller's Office. For patients that did not have matching data from the Comptroller's Office, HSCRC assumptions related to patient income to complete the modeling.

Patients with Known Incomes

For about 45% of patient visits to hospitals in 2017-2018, we know that these patients had income under 200% FPL for the year because HSCRC was able to match income ranges provided by the Comptroller's Office to the patients in HSCRC's case mix data for the year. Data

from the Comptroller's office provided HSCRC with an FPL statistic for the year, rather than indicating a patient's income at any point in time during that year.

Patients with Known Incomes in a different year than the patient visit.

Approximately 13% of patient visits had income data from either 2017 or 2018, but not both years. For the report under Chapter 470 (2020), HSCRC staff assumed that a patient's income data from one year applied to both years. HSCRC does not recommend making this assumption for purposes of this process as this may not be an accurate reflection of the patient's income in the year with the missing income data; the individual's financial status may have changed during that time period such that the patient was no longer eligible for free care.

Patients with Imputed Incomes

43% percent of the patient visits that HSCRC modeled as being eligible for free care for purposes of the report under Chapter 470 (2020) do not have income data from the Comptroller's Office for either 2017 or 2018. For these patients, HSCRC made assumptions about a patient's likely income for purposes of generating reasonable population-wide results. Most of these patients were enrolled in Medicare. National statistics from the Kaiser Family Foundation demonstrate that about 20% of Medicare beneficiaries have incomes below 200% FPL. For purposes of the analysis under Chapter 470 (2020), staff randomly assigned an income of under 200% FPL to 20% of the Medicare population with no known income. This approach made sense for the purposes of population-level modeling of future policies required under Chapter 470 (2020). On the individual level, HSCRC staff do not know which patients in this population had incomes under 200% FPL. HSCRC also made assumptions about the income distribution of other patients without known income data. Without income data, the only way for state agencies to identify if these people may have been eligible for financial assistance would be to match their data with data from the DHS, as individuals who are enrolled in certain social services programs are presumptively eligible for free care.

Average Estimated Out-of-Pocket Cost Per Patient

HSCRC does not know the exact amount that each patient paid for hospital visits in 2017 or 2018. HSCRC estimated likely out-of-pocket costs for the report under Chapter 470 (2020) using population-level data. These estimates were used to construct the $60 million figure.

State Agencies Cannot Determine Eligibility for free care

The state agencies do not have information on insurance denials or patient assets (see below). Without this information, state agencies cannot make a conclusive determination of eligibility for hospital free care. Hospitals need to check their records to determine if free care was not provided due to circumstances that were not evident in data available to the state agencies.

Insurance Denials

For any patient, regardless of whether their income is known or imputed, HSCRC's data does not show whether an insurance denial occurred. Insurance denials result in no cost sharing for the patient. In HSCRC's data set, insurance denials look like paid claims. Thus, even for patients with known income, HSCRC cannot definitively say if the patient is entitled to a refund under HB 694. Patients who did not make a payment, because no payment was due because of

an insurance denial, should not receive a “refund.” Hospitals will need to review their records to determine if a patient actually paid for the service before issuing a refund.

Assets, Asset Tests, and “Determination” of Eligibility for Free Care

For any patient, regardless of whether their income is known or unknown, HSCRC does not know the value of the patient’s assets. Some hospitals consider assets when determining eligibility for financial assistance. If a patient was denied financial assistance due to the legitimate application of an asset test by a hospital, no refund is due to the patient. Hospitals with financial assistance policies that allowed for asset tests between 2017 and 2021 would need to review their records to see if the patient was reviewed for financial assistance and denied based on assets.