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Memorandum of Understanding, Data Sharing and Nondisclosure Agreement, and Other Documents

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MEMORANDUM OF UNDERSTANDING

Between
Comptroller of Maryland (COM)
And
Maryland Department of Human Services (DHS),
And
Office of Maryland Women, Infants, and Children Food Program (WIC), a unit of the Maryland Department of Health (MDH),
And
Health Services Cost Review Commission (HSCRC)
And
Health Education and Advocacy Unit of the Office of the Attorney General (HEAU)
And
SIGNATORY HOSPITAL

I. Definitions

a. "COM" means the Comptroller of Maryland.

b. "Data" means all information required to fulfill the requirements of identifying and providing reimbursement to patients under the requirements of Md. Ann. Code, Health General Article ("HG") § 19-214.4, as specified in this Memorandum of Understanding (MOU), the attached Data Sharing and Nondisclosure Agreement (DSNA), and by the HSCRC. Data includes verification of any information described in this MOU. The non-matching data is in and of itself data. A data set from which a patient has been removed by a Party, which is shared with another Party, is itself data. Data includes tax information.

c. "DHS" means the Department of Human Services.

d. "DSNA" means the attached Data Sharing and Nondisclosure Agreement.

e. "HEAU" means the Health Education and Advocacy Unit of the Office of the Attorney General.

f. "HSCRC" means the Health Services Cost Review Commission.

g. "MDH" means the Maryland Department of Health.

h. "MHA" means the Maryland Hospital Association.

i. "MOU" means this Memorandum of Understanding.

j. “Party” means a signatory of this MOU.

k. “Parties” means all signatories of this MOU.

l. “Protected Health Information” (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium, as defined by the Health Information Portability and Accountability Act (HIPAA) regulations, 45 CFR § 160.103.

m. “Personally identifiable information” (PII) means information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other information that is linked or linkable to a specific individual. This includes “personal information” as defined in Md. Commercial Law § 14-3501(e).

n. “Reimbursement Law” means HG § 19-214.4.

o. “Signatory Hospital” means a hospital that has signed this MOU. Hospitals that are required to sign this Agreement are listed in Attachment C.

p. “State Agency” means any one of the following agencies: COM; the Maryland DHS; WIC; the HSCRC; and HEAU. “State Agencies” means all the above agencies.

q. “Summary Data” means Data that contains no PHI or PII and cannot be reidentified. Summary data may not include any data cell that contains a count that is less than or equal to ten (10). For example, if the total number of patients reported in a cell in a table is 9, that figure should be excluded from the table and replaced with an asterisk. If a cell in the table is omitted, it should not be possible to determine the number that was omitted from remaining cells.

r. “Tax Information” means the amount of income or any other particulars disclosed in a tax return required under the Tax-General Article, any return information required to be attached to or included in a tax return required under the Tax-General Article, and any additional information described in Tax-General Article § 13-201. “Tax Information” INCLUDES any information shared by the Comptroller under this Agreement, including, but not limited to:

    i. All information described in Tax-General Article § 13-201, Annotated Code of Maryland;

ii. Confirmation that an individual's income is above or below a certain amount; and

iii. Confirmation that an individual filed or did not file a tax return.

s. "WIC" means the Office of Maryland Women, Infants, and Children Food Program, a unit of the Maryland Department of Health.

II. Purpose and Legal Authority

Pursuant to HG § 19-214.4 (the Reimbursement Law), the Maryland General Assembly, requires that the HSCRC, in coordination with WIC, DHS, COM, HEAU, and MHA, develop and implement a process for identifying patients who paid for hospital services but may have qualified for free care during calendar years 2017 through 2021 and for reimbursing the identified patients. The purpose of this MOU is to establish the obligations and responsibilities of each party to implement HG § 19-214.4.

III. Parties and Terms

a. Parties

This Memorandum of Understanding (MOU), dated [MONTH][DAY], 2024, is hereby entered into by and between-

i. The Comptroller of Maryland ("COM");
ii. The Maryland Department of Human Services ("DHS");
iii. The Office of Maryland Women, Infants, and Children Food Program (WIC), a unit of the Maryland Department of Health
iv. The Health Services Cost Review Commission (HSCRC);
v. The Health Education and Advocacy Unit of the Office of the Attorney General (HEAU); and
vi. [ENTER HOSPITAL NAME] ("Signatory Hospital").

COM, DHS, WIC, the HSCRC, HEAU, and [ENTER HOSPITAL NAME] are each a "Party" to this MOU and may collectively be referred to as the "Parties."

b. Term

The term of this MOU commences on [MONTH][DAY], 2024, and ends June 30, 2026.

c. Cost

State Agencies shall submit reports to the HSCRC regarding costs incurred in implementing the Reimbursement Law, in the time and manner specified by the HSCRC. Each signatory hospital is responsible for a portion of the costs incurred by the State agencies in implementing HG § 19-214.4. The HSCRC shall allocate the State agencies' costs of implementing HG § 19-214.4 to all of the hospitals obligated to sign this MOU (see Attachment C for a list of hospitals) pursuant to HG § 19-214.4(h). The HSCRC shall provide each hospital with invoices specifying the amount owed to State agencies. Each signatory hospital shall provide payment to the HSCRC for the invoiced amount not later than 30 days after receiving the invoiced amount. The HSCRC shall provide each State agency with the amount owed to that State agency via interagency transfer. See Task 1 in Attachment D for further description of the process for reimbursing State agencies.

State Agencies shall take responsible precautions to control the cost of implementing HG § 19-214.4. If a State agency acquires an asset, including ordinary office supplies, for the purpose of this MOU, the state Agencies should only allocate the costs for that asset to costs paid under the MOU, if such asset is used primarily for work under this MOU. If the State agency acquires any equipment having an acquisition cost of $500 or more per unit and a useful life of more than one year, the State agency shall only allocate the depreciation cost, not the acquisition cost, to costs paid under this MOU.

IV. Treatment and Use of Data

a. Custodians of Data

i. In general

Each signatory hospital and state agency is a custodian of the data shared under this Agreement for the period that each entity possesses that data. Each signatory hospital and state agency must protect the data in a responsible manner that ensures data privacy and security and is in full compliance with the state and federal law. Each signatory involved in the exchange of data sets described in Task 2 of the Scope of Work (Attachment D) must abide by the DSNA (Attachment A). The DSNA is incorporated into the MOU by reference. An individual patient is not subject to the DSNA and may share their personal information with any person, including information previously exchanged between a hospital and a state agency as required in Task 2 of the Scope of Work.

ii. Officers, Employees, Subcontractors, and other Third-Parties.

Each signatory to this Agreement may provide data shared under this Agreement to their officers, employees, subcontractors, and other third-parties under contract with the

signatory solely for the purpose of executing the tasks under the Scope of Work (Attachment D).

iii. Data created outside of MOU

The Parties retain all rights and responsibilities associated with data that they created prior to or independent of this MOU.

b. Use of data

i. Use is limited

The use of Data under this MOU shall be limited to uses necessary for implementation, compliance, and enforcement of HG § 19-214.4, and the uses specified in paragraphs ii. – iv below. The use of data is described in the attachments to this MOU, including the attached DSNA (Attachment A) and Scope of Work (Attachment D).

ii. Data obtained through written consent

Data that a hospital or state agency obtains as a result of the written consent of the patient (such as a power of attorney document) is subject to the requirements of the terms of the document providing the written consent and not this agreement.

iii. Use of Summary Data

1. Public Disclosure:

Parties to this MOU may share aggregated summary data related to the implementation, compliance, and enforcement of HG § 19-214.4 and use in presentations, reports, or other communications with the public, including the legislature. Parties acknowledge that aggregated summary data may be available to the public.

2. Summary data reported to the HSCRC:

The DSNA Parties shall provide aggregated summary data to the HSCRC as specified in the attached scope of work. HSCRC shall share this data with any other party to the Agreement and may share this data with any person who is not a party to this agreement.

3. Reidentification prohibited:

To the extent that a party to this MOU obtains summary data under the MOU from another party, that receiving party may not attempt to reidentify that data.

iv. Public disclosure of PII and PHI:

Signatories may not share PII or PHI for a patient with any member of the public unless the patient consents to the disclosure.

v. Disclosure and commercial use prohibited:

Except as permitted under this MOU or as required by law, a signatory of this MOU may not use, sell, sub-lease, assign, give, or otherwise transfer data shared under this MOU to any subcontractor or other third-party. No commercial use for the Data is permitted under this MOU.

vi. Disagreements about data use

For data under this MOU that is obtained or created through methods other than a written consent form provided to HEAU, in the case of a disagreement between parties on the use of data, the HSCRC will determine the appropriate use.

c. PHI and PII

State agencies and hospitals may only use or share PHI or PII created or obtained under this MOU under the terms of the DSNA or the terms of a written consent from the individual patient to use or share such data. See the DSNA (Attachment A) for additional terms related to the sharing and use of PHI and PII.

V. Document Retention and Inspection

a. **In general:** Subject to paragraph (b) below, the Parties shall retain and maintain all records and documents related in any way to fulfilling the requirements of identifying and providing reimbursement to patients under HG § 19-214.4 for a period of five years after the end of the MOU and shall make them available for inspection and audit by authorized representatives of any State agency that is party to this MOU at all reasonable times. All records related in any way to the MOU are to be retained by the Parties for the entire time period.

b. **Data destruction under DSNA:** Data that is required to be destroyed under the terms of the DSNA will be destroyed on the timeline specified in the DSNA, not the timeline in paragraph (a) above.

c. **Audit or investigation:** In the event of an audit or investigation by a State Agency, the Party that is subject to the audit shall aid the State Agency conducting the audit, without additional compensation, to identify, investigate and reconcile any audit discrepancies or variances.

VI. Maryland Law

This MOU shall be construed, interpreted, and enforced according to the laws of the State of Maryland.

VII. Compliance with Laws

The Parties represent and warrant that they shall comply with all federal, State and local laws, regulations, and ordinances applicable to their activities and obligations under this MOU.

VIII. Information Technology

a. **Federal and state laws:** The Parties agree to abide by all applicable federal, State and local laws concerning information security.

b. **Hospitals:** Hospitals are required to adhere to internal policies on information protection in addition to all applicable federal and state laws.

c. **State agencies:** The State Agencies shall comply with current State and Department of Information Technology (DoIT) information security policy currently found at https://doit.maryland.gov/policies/Pages/20-07-IT-Security-Policy.aspx

d. **Breach Notification:** Each State agency shall notify HSCRC, HEAU and each of the signatory hospitals within twenty-four hours of the discovery of any-unauthorized access or successful attack to their respective system that accesses, processes or stores data or works created as a deliverable under this DSNA. A successful attack is an attack that results in third party access to or interference with data or deliverables in a party's system.

e. **Interaction of MOU and DSNA:** For the signatories of the DSNA, the rules in paragraphs (a)-(d) of this section apply in addition to the rules in the DSNA. If a conflict exists between the rules in this section and the DSNA, the more stringent rule applies.

f. **Contact information:** The contact information for the parties to this MOU are in Attachment B.

IX. Limited Termination

The parties to this MOU have a statutory obligation under HG § 19-214.4. This MOU supports that obligation.

A State Agency may terminate this Agreement to protect patient data. A party to this Agreement may not terminate this Agreement for any other reason.

Before terminating this Agreement to protect patient data, the State Agency should consider other mitigating actions to protect the data. The State Agency determines that mitigation actions are not sufficient to protect patient data, the Agency may terminate this agreement. The Agency terminating the Agreement must notify all Parties in writing within 30 days to the Agreement of the termination. Such notification must include an

explanation of why mitigating actions short of termination of this Agreement were not sufficient to protect patient data.

X. Modification to this MOU

Modifications to this MOU must be made only in writing and be signed by the authorized representative of each Party.

XI. Representatives

Each Party to this MOU shall have an MOU Monitor. The MOU Monitor for the Party shall be the primary point of contact for matters relating to this MOU.

The MOU Monitor for a signatory hospital shall contact the MOU Monitors for the State Agencies immediately if the signatory hospital is unable to fulfill any of the terms of this MOU or has any questions regarding the interpretation of the provisions of this MOU.

The MOU Monitor for a State agency shall contact the MOU Monitors for the other Parties to this MOU immediately if the State Agency is unable to fulfill any of the terms of this MOU or has any questions regarding the interpretation of the provisions of this MOU.

The MOU Monitors are listed in Attachment B.

XII. Schedule of Attachments Incorporated by Reference

a. All parties hereby agree that the following attachments are attached to, incorporated into and made an integral part of this MOU:

    i. Attachment A: Data Sharing and Nondisclosure Agreement

    ii. Attachment B: Parties' Points of Contact

    iii. Attachment C: Hospitals that are required to sign this Agreement

    iv. Attachment D: Scope of Work

b. The DSNA (Attachment A) applies to COM, DHS, WIC/MDH, and each of the signatory hospitals. All parties to the DSNA agree that the following attachments are attached to, incorporated into, and made an integral part of the DSNA.

    i. Attachment B: Parties' Points of Contact

ii. Attachment C: Hospitals that are required to sign this Agreement

iii. Attachment D: Scope of Work

iv. Attachment E: Certificate of Data Destruction Template

XIII. Signatures

In acknowledgment of the foregoing description of the requirements of this MOU, these authorized signatories of the Parties do hereby attest to their acceptance of the terms and conditions of this MOU.

Organization	Comptroller of Maryland
Signature	
Typed Name	
Title	
Date	

Organization	Department of Human Services
Signature	
Typed Name	
Title	
Date	

Organization	Office of Maryland Women, Infants, and Children Food Program, a unit of the Maryland Department of Health
Signature	
Typed Name	
Title	
Date	

Organization	Health Services Cost Review Commission
Signature	
Typed Name	
Title	
Date	

Organization	Health Education and Advocacy Unit of the Office of the Attorney General
Signature	
Typed Name	
Title	
Date	

Organization	[HOSPITAL]
Signature	
Typed Name	
Title	
Date	

Attachment A: DATA SHARING AND NONDISCLOSURE AGREEMENT

Between
Comptroller of Maryland (COM)
And
Maryland Department of Human Services (DHS),
And
Office of Maryland Women, Infants, and Children Food Program (WIC), a unit of the Maryland Department of Health,
And
[SIGNATORY HOSPITAL]

I. Definitions

a. "COM" means the Comptroller of Maryland

b. "Data" means all information required to fulfill the requirements of identifying and providing reimbursement to patients under the requirements of Md. Ann. Code, Health-General ("H.G.") § 19-214.4, as specified in the MOU, the attached DSNA, and by the HSCRC. Data includes verification of any information described in this MOU. The non-matching data is in and of itself data. A data set from which a patient has been removed by a Party, which is shared with another Party, is itself data. Data includes tax information.

c. "DHS" means the Department of Human Services

d. "DSNA" means this Data Sharing and Nondisclosure Agreement

e. "DSNA Party" means a signatory of this DSNA

f. "DSNA Parties" means all signatories of this DSNA

g. "HEAU" means the Health Education and Advocacy Unit of the Office of the Attorney General

h. "HSCRC" means the Health Services Cost Review Commission

i. "MDH" means the Maryland Department of Health

j. "MHA" means the Maryland Hospital Association

k. "MOU" means the Memorandum of Understanding that this DSNA is attached to.

l. “Protected Health Information” (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium, as defined by the Health Information Portability and Accountability Act (HIPAA) regulations, 45 CFR § 160.103.

m. “Personally identifiable information” (PII) means information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other information that is linked or linkable to a specific individual. This includes “personal information” as defined in Md. Commercial Law §14-3501(e).

n. “Reimbursement Law” means HG § 19-214.4

o. “Signatory Hospital” means a hospital that has signed this DSNA. Hospitals that are required to sign this Agreement are listed in Attachment C.

p. “State Agency” means any one of the following agencies: COM; DHS; WIC; the HSCRC; HEAU. “State Agencies” means all of the above agencies.

q. “Summary Data” means Data that contains no PHI or PII and cannot be reidentified. Summary data may not include any data cell that contains a count that is less than or equal to ten (10) is suppressed. For example, if the total number of patients reported in a cell in a table is 9, that figure should be excluded from the table and replaced with an asterisk. If a cell in the table is omitted, it should not be possible to determine the number that was omitted from remaining cells.

r. “Tax Information” means the amount of income or any other particulars disclosed in a tax return required under the Tax-General Article, any return information required to be attached to or included in a tax return required under the Tax-General Article, and any additional information described in Tax-General Article § 13-201. “Tax Information” INCLUDES any information shared by the Comptroller under this Agreement, including, but not limited to:

    i. All information described in Tax-General Article § 13-201, Annotated Code of Maryland;

    ii. Confirmation that an individual’s income is above or below a certain amount; and

    iii. Confirmation that an individual filed or did not file a tax return.

s. “WIC” means the Office of Maryland Women, Infants, and Children Food Program, a unit of the Maryland Department of Health.

II. Parties and Terms

a. Parties

This Data Sharing and Nondisclosure Agreement is entered into this ____ day of _____, 2023 by and between the Comptroller of Maryland ("COM"); Maryland Department of Human Services (“DHS”); Office of Maryland Women, Infants, and Children Food Program (WIC), a unit of the Maryland Department of Health; and [ENTER HOSPITAL NAME]. COM, DHS, WIC, and [ENTER HOSPITAL NAME] are each a "DSNA Party" and may collectively be referred to hereinafter as the "DSNA Parties."

b. Term

The term of this DSNA commences on [MONTH][DAY], 2023, and ends June 30, 2026.

III. Purpose and Legal Authority

The Reimbursement Law (HG § 19-214.4) requires that the HSCRC, in coordination with WIC, DHS, COM, HEAU, and MHA implement a process for identifying patients who paid for hospital services but may have qualified for free care during calendar years 2017 through 2021 and for reimbursing the identified patients. The purpose of this DSNA is to establish the obligations and responsibilities of each party that is exchanging PHI and PII as a component of this process.

IV. Description of Data

a. Dates of Service Covered by Data Sets

The Signatory Hospital shall provide COM, DHS, and MDH with a data set that will include patients receiving hospital services after December 31, 2016, and before January 1, 2022.

b. Data Elements in Hospital Data Set; Exclusion and Inclusion Rules

See the Scope of Work (Attachment D) for the following:

i. the data elements that are required in the data sets that the hospitals' share with COM,

ii. the rules for excluding patients from that data set, and

iii. the rules for including patients in that data set.

V. Compliance with Laws

The Data exchanged under this DSNA is personally identifiable information (PII) and are considered protected health information (PHI). The Parties consider the security and confidentiality of PII and PHI as a matter of high priority. Each Party (and any agents acting on behalf of the Party) having access to patient data under this DSNA will be held responsible for safeguarding and maintaining strict confidentiality. Each Party shall use the Data in compliance with the requirements of applicable State and Federal laws and the terms of this agreement. To be granted access to the Data, unconditional Agreement to the standards in this Agreement are required of each Party.

VI. Confidentiality and Security

The State Agencies that are Parties to the DSNA, having access to PII and PHI contained in the Hospital Data:

a. Will not share the Data with any individual or organization not named in this DSNA, except as permitted in the MOU Section IV (Treatment and Use of Data).

b. Will take affirmative measures to protect the Data from breach.

c. Will attest that all users of the Data received training in the protection of sensitive and confidential information.

d. Will not permit third parties to use, or attempt to use, the Data to learn the identity of any person included therein.

e. Will attest that the data security standards that are described in the DSNA Party's Data Security Plan meets the requirements of the MDH Data Use Policy 01.06.01 and are being applied.

f. Will adequately supervise employees to ensure Data are used only to administer the program.

g. Will ensure all work by Subcontractors will be done under the supervision of the relevant Parties employees.

h. Will require all users of the Data within the DSNA Party's organization to sign an Agreement ensuring full compliance with this DSNA. The DSNA Party will keep these signed agreements and make them available to the HSCRC during normal business hours and upon receipt of prior written notice.

i. Will maintain a data security plan for any subcontractor employed by the Party which adequately addresses the requirements contained herein.

j. Will not release or permit others to release any information that identifies persons, directly or indirectly, except as provided in this Agreement or as authorized by the identified person.

k. Will not release, publicize, or permit others to release or publicize statistics where the number of observations in any given cell of tabulated data is less than or equal to ten (10), except as provided under this agreement.

l. Will ensure that any subcontractors accessing the Data will use the Data only for the purposes identified above and will destroy the Data upon the termination of the agreement.

m. Will not attempt to link or permit others to attempt to link the hospital stay records of the persons in the data set with personally identifiable records from any source, except as provided in this agreement.

n. Will ensure that the transmission of PHI or PII is in full compliance with HIPAA[1], the Privacy Act[2], and all other applicable State laws and regulations.

o. Will give the parties to this DSNA and the attached MOU written notice immediately or as soon as reasonably practicable upon having reason to believe that a breach, as defined below, has occurred;

i. Any unauthorized use of the Data by the DSNA Party, including its subcontractors, or any other third-party, shall constitute a breach of this Agreement.

ii. Any breach of security or unauthorized disclosure of the Data by the subcontractors or other third-party under contract with the DSNA Party shall constitute a breach of this Agreement.

iii. Any violation of state or federal law with respect to disclosure of the Data by the DSNA Party, including but not limited to, HIPAA, shall constitute a breach of this Agreement.

iv. Notwithstanding the breaches specifically enumerated above, any other failure by the DSNA Party, including its subcontractors, or other third-parties, to comply with the terms and obligations of this Agreement shall constitute a breach of this Agreement.

v. Any breach of the Data by a subcontractor or other third-party will promptly:

1. cause the DSNA party with the relationship to the subcontractor or other third-party to terminate the contract with that third-party or another appropriate action against such subcontractor or other third-party, as determined by the DSNA Party reporting the breach; and
2. be reported to the other Parties of this DSNA and the attached MOU within two (2) business days of the day the DSNA Party becomes aware of the subcontractor or third-party violation.

[1] The Health Insurance Portability and Accountability Act of 1996 (HIPPA) sets national standards for patient rights with respect to health information. The Privacy Rule under HIPAA protects individually identifiable health information by establishing conditions for its use and disclosure by covered entities. For more information: http://www.hhs.gov/ocr/hipaa or http://privacyruleandresearch.nih.gov.

[2] The Privacy Act of 1974, a United States federal law, establishes a Code of Fair Information Practice that governs the collection, maintenance, use, and dissemination of PII about individuals that is maintained in systems of records by federal agencies. For more information: https://www.justice.gov/opcl/privacy-act-1974

vi. Any alleged failure of the DSNA Party to act upon a notice of a breach of this Agreement does not constitute a waiver of such breach, nor does it constitute a waiver of any subsequent breach(es);

vii. If any party to this DSNA or the attached MOU reasonably believes that the confidentiality of the Data has been breached, the HSCRC may require the DSNA Party to develop a plan of correction to ameliorate or minimize the damage caused by the breach of confidentiality and to prevent future breaches of data confidentiality.

viii. In the event of a breach of this Agreement, any party to this DSNA or the attached MOU may seek all other appropriate remedies for breach of contract, including, but not limited to, termination of this Agreement, disqualification of the Party from receiving PHI and PII from the other parties to this DSNA or the attached MOU in the future, and referral of any inappropriate use or disclosure to the Maryland Office of the Attorney General, or other appropriate individual or entity;

ab. Will retain these Data up until the termination of this Agreement;

ac. Will destroy the Data using defined sanitization techniques consistent with National Institute of Standards and Technology Special Publication (NIST SP) 800-88 (R1) and provide a Certification of Data Destruction to the HSCRC within thirty (30) days of termination of this agreement, per section VIII below. HSCRC will provide the Certificate of Data Destruction to all DSNA parties.

VII. Security Practices

a. All data will be accounted for upon receipt and properly stored before, during, and after processing, according to the procedures described in the Party's data security plan in Attachment G.

b. All computer systems processing, storing, or transmitting data must be consistent with the most current Maryland DoIT's Information Security Policies.

VIII. Limited Termination

The parties to this MOU have a statutory obligation under HG § 19-214.4, this MOU supports that obligation. Except as required to protect patient data, no party may terminate this agreement.

Before terminating this Agreement to protect patient data, the Parties should consider other mitigating actions to protect that data. If a Party to this Agreement determines that mitigation actions are not sufficient to protect patient data, the Party may terminate this agreement. The Party terminating the Agreement must notify all Parties in writing within 30 days to the Agreement of the termination. Such notification must include an explanation of why mitigating actions short of termination of this Agreement were not sufficient to protect patient data.

IX. Destruction of Data

At the conclusion of the term of this agreement, all parties shall certify that the data shared during the performance of this Agreement will be completely purged from all data storage components of its computer facility and destroyed, and no output will be retained. The parties will purge and destroy all data storage according to the procedures described in Attachment E. Prior to permanent purging, all parties certify that any data remaining in any storage component will be safeguarded to prevent unauthorized disclosures.

X. Required Supporting Documentation

DSNA parties must submit a Certification of Data Destruction to the HSCRC within thirty (30) days of termination of this agreement.

This document is required of all parties under this agreement.

There may be other documents that are required under other sections of this DSNA that are not listed here (for example, in the case of a breach).

XI. Signatures

The signatures below indicate agreement to comply with the above-stated requirements. All persons within the DSNA Party organization must fully comply with this agreement. Failure to comply with the provisions specified herein may result in civil and/or criminal penalties in accordance with state law and policy.

In acknowledgment of the foregoing description of the requirements of this DSNA, these authorized signatories of the Parties do hereby attest to their acceptance of the terms and conditions of this DSNA.

Organization	Comptroller of Maryland
Signature	

Typed Name	
Title	
Date	

Organization	Department of Human Services
Signature	
Typed Name	
Title	
Date	

Organization	Office of Maryland Women, Infants, and Children Food Program, a unit of the Maryland Department of Health
Signature	
Typed Name	
Title	
Date	

Organization	[HOSPITAL]
Signature	
Typed Name	
Title	
Date	

Attachment B: Parties' Points of Contact

A. Agreement Monitors

Organization	Comptroller of Maryland
Name	
Title	
Business Address	
Telephone Number	
Email Address	

Organization	Department of Human Services
Name	
Title	
Business Address	
Telephone Number	
Email Address	

Organization	Office of Maryland Women, Infants, and Children Food Program, a unit of the Maryland Department of Health
Name	
Title	
Business Address	
Telephone Number	

Email Address	

Organization	[HOSPITAL]
Name	
Title	
Business Address	
Telephone Number	
Email Address	

B. Data Custodians

Organization	Comptroller of Maryland
Name	
Title	
Business Address	
Telephone Number	
Email Address	

Organization	Department of Human Services
Name	
Title	
Business Address	
Telephone Number	

Email Address	

Organization	Office of Maryland Women, Infants, and Children Food Program, a unit of the Maryland Department of Health
Name	
Title	
Business Address	
Telephone Number	
Email Address	

Organization	[HOSPITAL]
Name	
Title	
Business Address	
Telephone Number	
Email Address	

C. Billing Contacts

Organization	Comptroller of Maryland
Name	
Title	
Business Address	

Telephone Number	
Email Address	

Organization	Department of Human Services
Name	
Title	
Business Address	
Telephone Number	
Email Address	

Organization	Office of Maryland Women, Infants, and Children Food Program, a unit of the Maryland Department of Health, Maryland Department of Health
Name	
Title	
Business Address	
Telephone Number	
Email Address	

Organization	[HOSPITAL]
Name	
Title	
Business Address	
Telephone	

Number	
Email Address	

Attachment C: Hospitals that are required to sign this Agreement

The following hospitals are subject to the requirements of HG § 19-214.4 and must sign this agreement.

1. Adventist Shady Grove Medical Center	2. MedStar Southern Maryland Hospital
3. Adventist Fort Washington Medical Center	4. MedStar Union Memorial Hospital
5. Adventist White Oak Medical Center	6. Mercy Medical Center
7. Anne Arundel Medical Center	8. Meritus Medical Center
9. Atlantic General	10. Northwest Hospital
11. Calvert Memorial Hospital	12. Sinai Hospital
13. Carroll Hospital Center	14. St. Agnes Hospital
15. Christiana Care Union of Cecil Hospital	16. Suburban Hospital
17. Doctor's Community Hospital	18. TidalHealth Peninsula Regional Medical Center
19. Frederick Health Hospital	20. UM Baltimore Washington Medical Center
21. Garrett County Memorial Hospital	22. UM Capital Region Medical Center
23. GBMC	24. UM Charles Regional Medical Center
25. Holy Cross Hospital	26. UM Harford Memorial Hospital
27. Holy Cross Hospital- Germantown	28. UM Shock Trauma

29. Howard County General Hospital	30. UM Shore Health at Chestertown
31. Johns Hopkins Bayview Medical Center	32. UM Shore Health at Easton
33. Johns Hopkins Hospital	34. UM St. Joseph Medical Center
35. Levindale (chronic care hospital)	36. UMMC Midtown
37. MedStar Franklin Square Medical Center	38. UMROI
39. MedStar Good Samaritan Hospital	40. University of Maryland Medical Center
41. MedStar Harbor Hospital	42. UPMC Western Maryland Medical Center
43. MedStar Montgomery General Hospital	44. Upper Chesapeake Medical Center
45. MedStar St. Mary's Hospital	

Specialty hospitals (pediatric, rehabilitation, and psychiatric hospitals) and free-standing medical facilities are not required to sign the MOU or DSNA.[3]

[3] Because HG § 19-214.4 relates to refunds for financial assistance required under HG § 19-214.1, § 19-214.4 only applies to hospitals that are subject to the requirements of § 19-214.1. HG § 19-214.1(b) states that the Commission "shall require each acute care hospital and each chronic care hospital under the jurisdiction of the Commission to develop a financial assistance policy for providing free and reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill." This language refers to licensure categories. This means HG § 19-214.4 applies to general acute care hospitals and to Levindale (a chronic care hospital). This law does not apply to HSCRC regulated specialty hospitals (i.e., pediatric, rehabilitation, and psychiatric hospitals) or free-standing medical facilities (FMFs).

Attachment D: Scope of Work

ADD TEXT

Task 1: Reimbursement of State Agencies

Subject to HG § 19-214.4(h)(1), each hospital shall reimburse COM, MDH, DHS, the HSCRC, and HEAU for the costs incurred by each State agency for complying with HG § 19-214.4, as amended by CH 310 (2023). The following process will be used to reimburse the State agencies.

1.1 State agencies report resource use

1.1.1 State agencies will record their incurred costs (staff time and other resource use).

1.1.2 State agencies will record any costs incurred on or after July 1, 2023. The HSCRC recommends that State agencies use the same process they use for tracking staff time and other resources spent on Public Information Act (PIA) requests.

1.1.3 State agencies will maintain the records of staff time and other costs for this project.

1.1.4 State agencies will report to the HSCRC, at times specified by the HSCRC, the total costs (the cost of staff time and other costs) associated with this project for each period specified by the HSCRC. The HSCRC currently plans to require this reporting annually but may request reporting more frequently. The HSCRC shall not require this reporting more frequently than quarterly.

1.3 The HSCRC determines amount owed by hospitals

1.3.1 Total state agency costs: The HSCRC will sum the total costs reported by all State agencies under task 1.1.

1.2.2 Each hospital's share of total costs:

1.2.2.1 De facto eligibles per hospital: The HSCRC will sum the number of patients identified as de facto eligible for a refund for each hospital, as reported by COM, DHS, and WIC/MDH, as reported to HSCRC under task 4.

1.2.2.2 Statewide de facto eligibles: The HSCRC will sum the number of patients identified as de facto eligible for a refund for all hospitals, as reported by COM, DHS, and WIC/MDH, to determine the total statewide number of de facto eligibles as reported to HSCRC under task 4.

1.2.2.3 Hospital share of total eligibles: The HSCRC will determine the percent of patients identified as de facto eligible for a refund for each hospital, compared to the statewide total of such patients.

1.2.2.4 Amount owed by hospital: The HSCRC will determine the amount each hospital owes to the State agencies by multiplying the following amounts:

- the total costs incurred by state agencies as reported under task 1.1
- the percent of patients identified as de facto eligible for refunds by the state agencies, as calculated in task 1.2.2.3.

Formula for determining the amount owed by each hospital:

$$Amount\ hospital\ A\ owes = (Sum\ of\ costs\ for\ COM, MDH, DHS, the\ HSCRC, and\ HEAU\ for\ the\ period\ ) * \left(\frac{Number\ of\ patients\ de\ facto\ eligible\ for\ free\ care\ for\ hospital\ A\ in\ increment}{Number\ of\ patients\ de\ facto\ eligible\ for\ free\ care\ for\ all\ hospitals\ in\ increment}\right)$$

1.3 Collection and Distribution of Payment

1.3.1 Invoices:

1.3.1.1: The HSCRC will invoice each hospital for the amount each hospital owes. The invoice shall contain, at a minimum, the following information:

i. Name and remittance address

ii. Amount of invoice, itemized to show the cost allocated for each State agency for which payment is requested

iii. Period covered by the invoice for costs incurred

iv. Title of project

1.3.1.2: Invoices shall be sent to the hospital billing office contacts in Attachment B.

1.3.2 Hospital payment to the HSCRC: Each hospital must pay the invoiced amount to the HSCRC within 45 days of receiving the invoice.

1.3.3 Timing of invoices: Invoices will be sent to hospitals quarterly after the State agencies complete data matching for all hospitals.

1.3.4 HSCRC transfer of payments to other agencies:

1.3.4.1 In general: The HSCRC will transfer the amount owed to each State agency that reported costs under task 1.1 using an interagency transfer.

1.3.4.2 State close-out: Due to the process for calculating the hospital share of total costs, State agencies may not be reimbursed for their incurred costs before the close-out period ends for the fiscal year in which those costs were incurred.

Task 2: Identification of Patients Eligible for Refunds and Provision of Refunds

The Reimbursement Law requires the HSCRC, in coordination with the State Agencies and MHA, to develop a process to identify patients who paid more than $25 for hospitals services who may have qualified for free care under HG § 19–214.1 on the date the hospital service was provided during calendar years 2017 through 2021. This identification will be completed using patient data from hospitals, income data from COM and program enrollment data from DHS (SNAP and MEAP) and MDH (WIC). The process for identifying eligible patients and providing refunds is described below.

The numbers of the steps in this document match the numbers in the flow chart attached to this document.

2.1 Hospitals create a data set of patients who paid bills

2.1.1 Data set requirement:

2.1.1.1 In general: Each hospital will produce a data set that meets specifications determined by the HSCRC.

2.1.1.2 Template: The HSCRC will provide hospitals with a template and instructions for the data set.

2.1.1.3 File name: Each hospital shall follow the file naming convention specified by the HSCRC for the file transfer to COM, DHS, and MDH.

2.1.1.4 PII/PHI: The data set will contain PII/PHI for patients of the hospital.

2.1.1.5 First data set timeline: Each hospital will produce the data set within 30 days of execution of the MOU.

2.1.2 Data elements:

2.1.2.1 Purpose of data elements: The required data elements listed in task 2.1.2.2 are included in the data set for one or more of the following purposes:

i. to allow for data matching;
ii. to allow the hospital to create the summary data that will be reported separately to the HSCRC, for oversight and legislative reporting; and/or

iii. to allow the hospital to identify the patients who contact them about refunds.

2.1.2.2 Required data elements: Except as provided in 2.1.2.3 below, each data set created by each hospital for the purpose of identifying patients eligible for refunds must contain the following data elements for each patient for each year, to the extent that the data is in the possession of the hospital:

List of Data Elements

a. Hospital Name
b. Hospital Number
c. Patient Medical Record Number
d. Patient FirstName
e. Patient MiddleName
f. Patient LastName
g. Patient Social Security Number (if available)
h. Patient Home Address1
i. Patient Home Address2
j. Patient Home City
k. Patient Home State
l. Patient Home ZIP
m. Patient Mailing Address 1
n. Patient Mailing Address2
o. Patient Mailing City
p. Patient Mailing State
q. Patient Mailing ZIP
r. Patient DOB
s. Patient Gender
t. Patient Home_Phone
u. Patient Work_Phone
v. Patient Cell_Phone
w. Patient Email address
x. Guarantor First Name
y. Guarantor MiddleName
z. Guarantor LastName
aa. Guarantor Social Security Number
bb. Guarantor Home Address1
cc. Guarantor Home Address2
dd. Guarantor Home City
ee. Guarantor Home State
ff. Guarantor Home ZIP
gg. Guarantor Mailing Address 1

hh. Guarantor Mailing Address2

ii. Guarantor Mailing City

jj. Guarantor Mailing State

kk. Guarantor Mailing ZIP

ll. Guarantor DOB

mm. Guarantor Gender

nn. Guarantor Home_Phone

oo. Guarantor Work_Phone

pp. Guarantor Cell_Phone

qq. Guarantor Email address

rr. Year of Date of Service

ss. Date of Service Start Date

tt. Date of Service End Date

uu. Out of pocket amount paid for the regulated service

vv. Full Charge for the HSCRC regulated service

ww. Encounter numbers

2.1.2.3 Exclusion of Social Security Numbers from data sent to MDH: The hospital shall not include the SSN field in the data set sent to WIC/MDH under task 2.2 below.

2.1.3 Dates of service:

2.1.3.1 Covered years: The Reimbursement Law requires that hospitals share data for dates of service between January 1, 2017, and December 31, 2021. These calendar years are referred to as “covered years”.

2.1.3.2 Number of data sets: Each hospital shall create a single data set to send to MDH, DHS, and COM. The data set will include data for all patients with a date of service between January 1, 2017, and December 31, 2021 who paid an out-of-pocket (OOP) amount on a hospital bill.

2.1.4 Optional exclusions

2.1.4.1 OOP $25 or less:

2.1.4.1.1 In general: In accordance with HG § 19-214.4(a)(1), hospitals may exclude data for patients who paid at or below a total of $25 in OOP expenses for the sum of all admissions and visits with dates of service in a covered year. For example:

i. Patient B received hospital services on June 1, 2017, and paid $20 OOP for that service. That was Patient B’s only visit or admission in the year. Signatory Hospital may **exclude**

from the data set all elements for Patient B's June 1, 2017 visit or admission.

ii. Patient B received hospital services on July 1, 2017, and paid $30 OOP. Signatory Hospital is required to **include** in the data set all available data elements for Patient B's July 1, 2017 visit or admission.

iii. Patient B received hospital services once a week for a month. For each visit, Patient B paid $20, for a total OOP payment of $80. Signatory Hospital is required to **include** in the data set all available data for Patient B's 2017 visits or admissions.

2.1.4.1.2 Annual OOP amount: For purposes of the optional exclusion in task 2.1.7.1, the amount of OOP expenses paid by a patient or guarantor shall be determined separately for each covered year.

2.1.4.1.3 OOP amount is based on year of date of service: To determine the OOP amount paid by a patient or guarantor for a covered year for purposes of the optional exclusion in task 2.1.7.1, the hospital shall sum the amounts that the patient or guarantor paid OOP for all visits and admissions for that patient with a date of service in the covered year. If payments are made in a subsequent year for a date of service in the covered year, those payments will be included in the calculation of the OOP amount paid for the covered year with the associated visit or admission, not the year in which the payment was made. For visits and admissions that start in one year and end in the following year, the hospital shall use the start date of that visit or admission for this calculation.

2.1.4.2 Medical necessity: Hospitals may exclude data for services that were not medically necessary. Hospitals are only required to provide refunds for services that were medically necessary. Hospitals shall follow the same procedures for determining medical necessity that they follow for determining if a visit and/or admission is medically necessary when determining eligibility for financial assistance under HG § 19-214.1.

2.1.4.3 Non-regulated services:

2.1.4.3.1 In general: Hospitals may exclude data for paid OOP amounts and charges for services that are not regulated by the HSCRC. Services that are not regulated by the HSCRC are not

subject to HG § 19-214.1 and thus are not subject to the requirements of the Reimbursement Law.

2.1.4.3.2 Relationship to $25 optional exclusion: If the exclusion of amounts for services that are not regulated by the HSCRC lowers the total OOP amount paid by the patient or guarantor for the year below $25, the Signatory Hospital may **exclude** the patient's data for that year. See task 2.1.5.1 for explanation of the $25 optional exclusion. For example:

1. Patient C received a combination of regulated and non-regulated services in 2017 and paid $75 OOP. $20 was paid for services not regulated by the HSCRC; $55 was paid for services regulated by the HSCRC. The Signatory Hospital shall **include** in the data set all elements for Patient C's 2017 visits or admissions for HSCRC regulated services. The hospital shall report the OOP costs for 2017 as $55 and only the HSCRC-regulated charge amount should be included in the full charge data element.

2. Patient C received a combination of regulated and non-regulated services in 2017. The patient or guarantor paid $55 OOP for services not regulated by the HSCRC and paid $20 OOP for services regulated by the HSCRC. The Signatory Hospital may **exclude** from the data set all elements from Patient C's September 1, 2017, occurrence.

2.1.4.3.3 Reimbursement allowed: Under HG § 19-214.4, hospitals are required to refund patients the OOP amounts for regulated charges. A hospital may reimburse patients identified through the Reimbursement Law process for services that are not regulated by the HSCRC, but reimbursement for non-regulated charges is not required by law.

2.1.4.4 State residency:

2.1.4.4.1 Exclude out-of-state residents: Hospitals may exclude data for patients whose residency on the date of service (if known) is not in the State of Maryland. For example:

i. March 1, 2017, Patient A received services and provided a home address in Virginia. Signatory Hospital may **exclude**

from the data set all data elements for Patient A's March 1, 2017, occurrence.

ii. On April 1, 2018, Patient A received services and provided a home address in Maryland. Signatory Hospital shall **include** in the data set all available data elements for Patient A's April 1, 2018, occurrence.

iii. On May 1, 2019, Patient A received services and did not provide a home address. Signatory Hospital shall **include** in the data set all available data elements for Patient A's May 1, 2019, occurrence.

2.1.4.4.2 Address as proxy for residency: Hospitals may use the patient's address on the date of service as a proxy for determining state residency.

2.1.4.4.3 Limitation on exclusion for residence: Hospitals may not exclude patients whose address on the date of service was in-State and whose current address is out-of-state, as all eligibility for refunds under this bill is based on the patient's status on the date of service.

2.1.5 Inclusions: The data set produced by the hospital will meet the following rule:

2.1.5.1 OOP over $25: Hospitals shall include data for patients who paid more than $25 in OOP expenses for all admissions and visits with dates of service in a covered year. The hospitals shall follow the rules in task 2.1.7 to determine the OOP amount.

2.1.5.2 Regulated charge: Hospitals shall include the OOP amounts and total charges for HSCRC-regulated charges.

2.1.5.3 State residency: For purposes of this reimbursement program, hospitals shall include patients whose address on the date of service (if known) was in Maryland. If the patient's address on the date of service is not known, the hospital shall use the most recent address available for the patient to determine residency. If the hospital does not have any record of the patient's address, the hospital shall include the patient.

2.1.5.4 Deceased patients: Hospitals shall include data for patients who the hospital knows are deceased. Under Maryland law, the legal obligation to pay a debt, such as a refund under the Reimbursement Law, does not end on the death of a patient.

2.1.5.5 Patients with substance abuse: Hospitals shall include data for patients treatment covered by Part 2 of Title 42 of the Code of Federal Regulations because the requested data elements do not include any information about diagnoses or services received.

2.2 Hospitals transfer data to COM, DHS, and WIC

Each hospital shall securely transfer the data set to COM, DHS, and WIC as soon as it is produced and not later than 21 calendar days after the hospital signs the MOU and DSNA. COM, DHS, and MDH/WIC shall provide technical instructions for the secure transfer of this data.

2.3 Data matching by COM

2.3.1 In general: COM, within 30 days of receipt, shall match each data set provided by each hospital in task 2.2 with tax information to identify patient income.

2.3.2 Data matched for the same year: The tax information from a filing year will be matched to patient data for dates of service in the same year. Patient data from one year will not be matched to tax information from a different year, patient data for a year with a date of service will only be matched to tax information for that same year.

2.3.3 Methodology: COM shall develop a data matching methodology and consistently follow that methodology for all data matching under Task 2. In matching patient data, COM will consider tax information for the tax filer, spouse, and/or dependents. COM will identify patients with household incomes being at or below 200% of the federal poverty level in the year of the date of service as potentially eligible for a hospital refund.

2.4 DHS data matching

2.4.1 In general: Within 30 days of receipt, DHS shall match each data set provided by each hospital in task 2.2 with SNAP and MEAP data to identify patients enrolled in those programs during the year of the date of service.

2.4.2 Data matched for the same year: The DHS enrollment data will be matched to patient data for dates of service in the same year. Data will not be matched across years.

2.4.3 Methodology: DHS shall develop a data matching methodology and consistently follow that methodology for all data matching under Task 2. In matching patient data, DHS will consider program enrollment data for family members of the patient. DHS will identify patients enrolled in SNAP or MEAP in the year of the date of service as potentially eligible for a hospital refund.

2.5 WIC/MDH data matching

2.5.1 In general: Within 30 days of receipt, WIC/MDH shall match each data set provided by each hospital in task 2.2 with WIC program enrollment data to identify patients enrolled in WIC during the year of the date of service.

2.5.2 Data matched for the same year: The WIC enrollment data will be matched to patient data for the same year as the dates of service. Data will not be matched across years.

2.5.3 Methodology: WIC/MDH shall develop a data matching methodology and consistently follow that methodology for all data matching under Task 2. In matching patient data, WIC will consider program enrollment data for the family members of the patient. WIC will identify patients enrolled in WIC in the year of the date of service as potentially eligible for a hospital refund.

2.6 State Agencies notify matched patients

2.6.1 Office of the Comptroller: For patients in households with incomes at or below 200% of the federal poverty level, the Office of the Comptroller shall send a letter to the appropriate addressee under 2.6.5. This letter will inform the addressee that they may be eligible for a refund from the hospital. The Office of the Comptroller shall send letters in batches, every 30 days starting 45 days after the receipt of the first data from a hospital.

2.6.2 DHS: For patients in households enrolled in SNAP or MEAP, DHS shall send a letter to the appropriate addressee under 2.6.5. This letter will inform the addressee that they may be eligible for a refund from the hospital. DHS shall send letters in batches, every 30 days starting 45 days after the receipt of the first data from a hospital.

2.6.3 MDH/WIC: For patients in households enrolled in WIC, WIC/MDH shall send a letter to the appropriate addressee under 2.6.5. This letter will inform the addressee that they may be eligible for a refund from the hospital. WIC/MDH shall send letters in batches, every 30 days starting 45 days after the receipt of the first data from a hospital.

2.6.4 Purpose: The purpose of the letters sent by COM, DHS, and WIC under task 2.6 is to inform the addressee of their eligibility for a refund under the reimbursement process and direct that individual to contact the hospital.

2.6.5 Addressee: Each state agency shall send a message to either-

i. each patient who is identified as de facto eligible for a refund through the reimbursement process and who is not disqualified for such a refund under task 2.12 above; or

ii. in the case that the relevant OOP amount for such a patient was paid by a guarantor, the guarantor.

2.6.5 Content of message:

2.6.5.1 Template: The HSCRC shall provide COM, DHS, and WIC with a template for the message to patients and guarantors.

2.6.5.2 Minimum information necessary: The HSCRC will design the template to contain minimal information about the patient.

2.6.5.3 Prohibited content: The message may not contain information on the hospital services provided to the patient or the patient's diagnosis.

2.6.6 Method of contact:

2.6.6.1 Written letter: COM, DHS, and MDH/WIC may contact the patient or guarantor through a secure portal or a physical letter contained in an envelope.

2.6.6.2 Restriction on Portal Use: A state agency may only use a secure portal to contact a patient or guarantor if the state agency has evidence that the patient or guarantor actively uses the portal.

2.6.6.3 Email, text, phone, and postcards prohibited:

2.6.6.3.1 In general: The state agency may not send the content of the message under task 2.6. through email, text messages, phone, or postcards.

2.6.6.3.2 Messages generated by portal: To the extent that a secure portal contacts a patient or guarantor by email, text, or other method with a generic message to inform them that a new message has been posted in the portal, that contact is permitted.

2.6.6.4 Safe address: If the hospital provided a safe address for the patient or guarantor, the state agency shall use the safe address to mail any letter to the patient or guarantor under this process.

2.6.6.5 No safe address:

2.6.6.5.1. COM: If the hospital did not provide a safe address, COM should use the most recent mailing address the hospital has on file.

2.6.6.5.2. DHS: If the hospital did not provide a safe address, DHS should use the most recent of the following:

i. the most recent mailing address the hospital has on file; or

ii. the most recent mailing address DHS has on file.

2.6.6.5.3. WIC: If the hospital did not provide a safe address, WIC should use the most recent of the following:

iii. the most recent mailing address the hospital has on file; or

iv. the most recent mailing address WIC has on file.

2.6.7 Number of contacts:

2.6.7.1 Two times: The state agency shall contact each patient or guarantor at least two times to inform them of the refund.

2.6.7.2 Ten days between contacts: Each subsequent contact from the state agency shall be at least 10 days after the prior contact.

2.6.7.3 Special rule for portal messages: If the patient or guarantor does not respond to the first in the secure portal, the State agency shall make the second contact through a mailed letter.

2.7 The Patient Contacts the Hospital

2.7.1 Patient/Guarantor with Letter: A patient or guarantor who received a letter from a state agency shall contact the hospital, following the directions in the letter. This contact can be by mail, telephone, patient portal, in person, or any other method used by the patient.

2.7.2. Patient/ Guarantor without Letter: A patient or guarantor without a letter from a state agency may contact the hospital seeking a refund.

2.8 The hospital confirms patient eligibility of patients with Letters

2.8.1 De facto evidence of eligibility: Each hospital shall consider a letter from a State Agency provided by a patient as de facto evidence of the patient's eligibility for free care under Maryland's financial assistance law.

2.8.2 Medical necessity:

2.8.2.1 Review permitted: Each hospital may review the encounters for the patients who are de facto eligible for free care to determine if the patient received medically necessary services. Reviews must be completed within 15 days of receiving the data sets in tasks 2.4, 2.7, and 2.11.

2.8.2.2 Denial of refund allowed: Hospitals may deny a reimbursement under the reimbursement process for encounters and/or admissions that were not medically necessary (such as certain elective cosmetic surgeries). Hospitals shall

follow the same procedures for this determination that they follow for determining if a visit and/or admission is medically necessary when determining eligibility for financial assistance under HG § 19-214.1.

2.8.2.3 Limitation. A hospital may not deny a refund for the OOP amount paid by a patient or guarantor for medically necessary care.

2.8.2.4 Definition of medically necessary care: Medically necessary care means that the service or benefit is:

i. directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;
ii. consistent with current accepted standards of good medical practice; and
iii. not primarily for the convenience of the consumer, family, or the provider.

2.8.3 Application of Asset Test:

2.8.3.1 In general: If the hospital had a valid asset test in effect in the year of the date of service and the hospital previously denied the patient free care for the identified date of service in accordance with a valid asset test that was in effect on the date of service, the hospital is not required to provide a refund to a patient.

2.8.3.2 Valid asset test: A valid asset test is an asset test that was in the hospital's financial assistance policy in the year of the relevant date of service and the asset test that met all statutory and regulatory requirements in place in that year.

2.8.3.3 Decision to review de facto eligibles and documentation: If a hospital decides to review de facto eligible patients for past denials based on a valid asset test, before the hospital disqualifies patients based on the previously applied asset test, the hospital must provide the HSCRC and HEAU with a copy of the following documents by the date the hospital signs the MOU:

i. each asset test in effect during 2017 through 2021,

ii. a written statement that the hospital intends to deny refunds based on prior application of asset tests for the purposes of implementing the Reimbursement Law, and

iii. a written statement the hospital intends to review all de facto eligibles for past denials based on the valid asset test.

2.8.3.4 Past denial: In order to deny a refund based on a valid asset test, the hospital must be able to produce evidence that the hospital previously denied the patient's application for financial assistance and the underlying documentation

supporting a previous denial for that date of service based on application of the valid asset test.

2.8.3.5 Hospitals without asset tests: A hospital that did not have a valid asset test in the hospital's financial assistance policy in the year of the patient's date of service may not deny a refund to a patient identified as de facto eligible for a refund based on an asset test.

2.8.3.6 Hospitals without denial record: A hospital that does not have a record of denying the patient financial assistance due to an asset test in the year of the date of service for which the patient was identified as de facto eligible for a refund may not deny a refund to that patient for that year.

2.8.3.7 Timeline: Reviews of asset tests for purposes of confirming or denying a patient's eligibility for a refund must be completed within 15 days of receiving data sets in tasks 2.4, 2.7, and 2.11.

2.8.4 Additional Limitation on Denials of Refunds- Residency: A hospital may not disqualify a patient from receiving a refund if their current residency is out-of-state, provided the patient was a state resident on the relevant date of service.

2.8.5 Current Balance: If the patient has a current balance on their account that is not eligible for a refund under the Reimbursement Law, the hospital may apply the refund to that balance rather than following tasks 2.13 through 2.15 for that patient. The hospital must provide the patient with clear notice of the amount that the balance is being reduced and that the balance is being reduced because the patient was eligible for free care in the relevant year under the Reimbursement Law.

2.9 Patients with no letters

2.9.1 **Confirm Paid Bill.** If a patient or guarantor contacts the hospital and does not have a letter from a state agency, the hospital shall confirm that the patient paid a bill for a hospital service with a data of service in 2017, 2018, 2019, 2020, or 2021.

2.9.2 **Patient provides evidence of eligibility.** The hospital shall request that the patient provide proof of income or SNAP, MEAP, or WIC enrollment in the year of the date of service, to demonstrate potential eligibility for a refund. The hospital may use their financial assistance application as a tool to collect this information.

2.9.3 **Determination of Eligibility:**

2.9.3.1 **In General.** The hospital shall determine, based on the information available to them, including information provided by the patient, whether the patient is eligible for a refund.

2.9.3.2. **Inclusions and Exclusions.** The inclusions and exclusions under tasks 2.1.4, 2.1.5, 2.8.2, 2.8.3, and 2.8.4 apply to the hospital's determination of eligibility for refunds for patients who do not have a letter from a state agency.

The hospital provides a refund

2.9.1 State Agency Letters: Within 10 days of a patient or guarantor with a letter from a state agency contacting a hospital under 2.8.1, the hospital will send the patient or guarantor a refund for the OOP amount paid for the date of service for which the patient qualified for a refund under this reimbursement process.

2.9.2 No State Agency Letter: Within 10 days of a patient or guarantor providing the required proof of income or program enrollment under 2.8.2, the hospital will send the patient or guarantor a refund for the OOP amount paid for the date of service for which the patient qualified for a refund under this reimbursement process.

2.9.3 Refund recipient: The hospital will send the refund to-

i. the patient if the patient paid for the date of service for which the patient qualified for a refund, or

ii. the guarantor if the guarantor paid for the date of service for which the patient qualified for a refund.

2.9.4 Refund amount:

2.9.4.1 In general: The refund amount is the amount paid directly by the patient or guarantor (i.e., OOP payments), not amounts covered by a third party, such as an insurer (whether paid directly to the hospital or to the patient).

2.9.4.2 Payment dates: The refund amount includes any OOP payments made for the date of service on which the patient was eligible for a refund, regardless of the date the payment was made.

2.9.6 Outstanding amounts:

2.9.6.1 **In general:** If the patient has outstanding debt related to the date of service for which the patient was determined to be eligible for free care (i.e., the patient made partial payments towards that debt), the hospital shall forgive the outstanding amount, as the patient was eligible for free care for that service.

2.9.6.2 **Credit report:** The hospital shall also remove any negative tradeline on the patient's or guarantor's credit report, if applicable.

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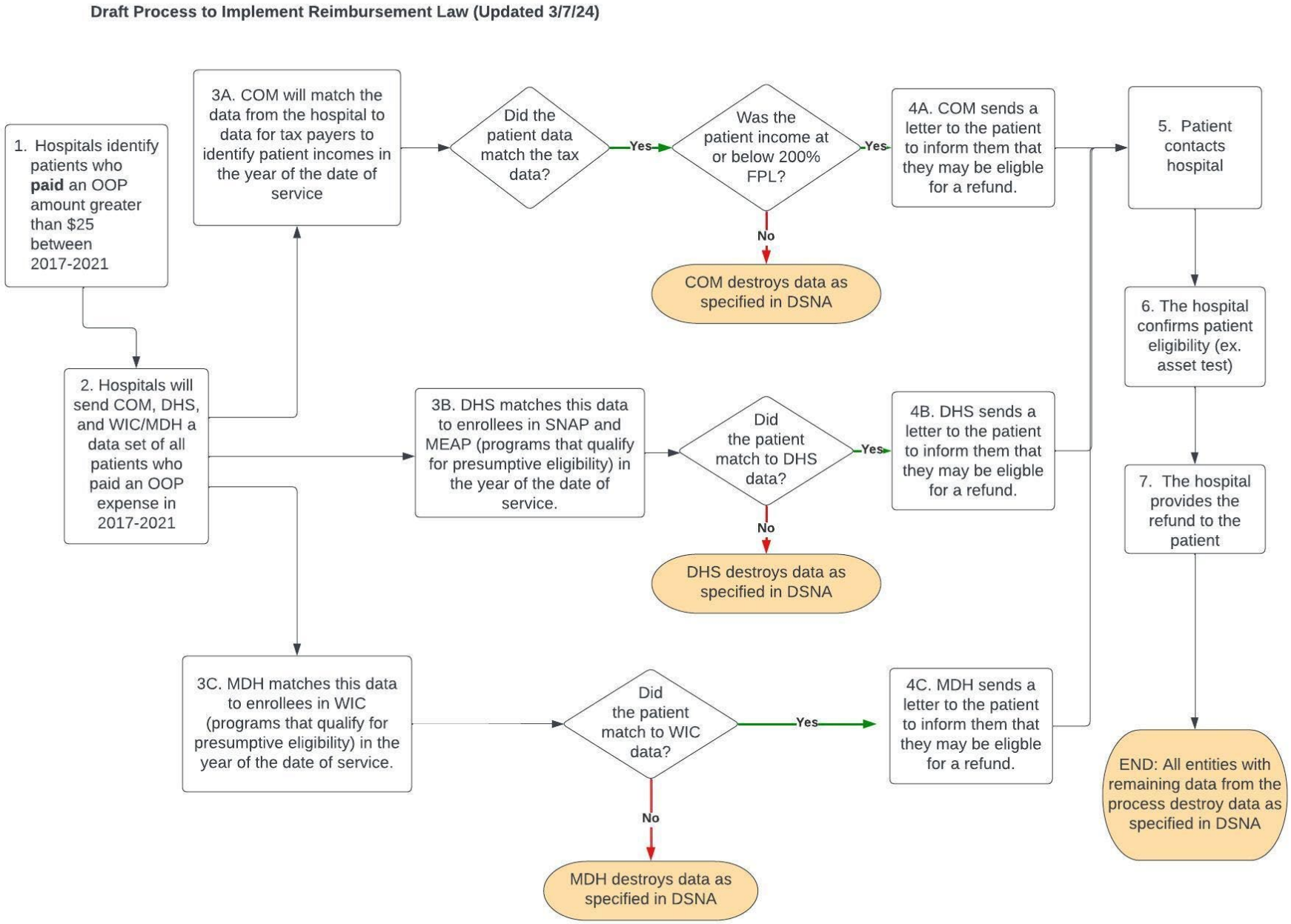

Task 3: Supporting Patients & Patient Complaints

3.1 Hospitals are the primary contact for their patients:

3.1.1 First point of contact: Each hospital is the first point of contact for the patients of that hospital regarding the reimbursement process and the availability of patient refunds under that process.

3.1.2 Patient support required: Each hospital shall provide appropriately staffed support to their patients regarding the reimbursement process and the availability of patient refunds.

3.1.3 Webpage required:

3.1.3.1 In general: Each hospital shall create a webpage that includes:

i. Information about the reimbursement process, including the process to be followed by a patient as well as relevant timelines; and
ii. A telephone number and email address that a patient may use to submit questions about the reimbursement process.

3.1.3.2 Template: Each hospital shall use the template language provided by the HSCRC for this webpage.

3.1.3.3 Location: The webpage link should be on the front page of the hospital website in a clear and conspicuous location.

3.1.3.4 **Legal Compliance:** The webpage must meet all relevant legal requirements under state and federal law, including legal requirements related to accessibility and language access.

3.2 HEAU is the secondary point of contact:

3.2.1 In general: HEAU will provide support to patients who are not able to resolve their questions or concerns directly with the hospital.

3.2.2 Patient assistance: HEAU will assist patients who believe they were eligible for refunds but did not receive a refund.

3.2.3 Confirming authenticity of eligibility outreach: HEAU will assist patients contacted by a hospital about their eligibility for a refund who are concerned about the authenticity of the contact by reviewing and confirming authenticity.

3.2.4 Release forms: HEAU will seek records and responses from hospitals using the HEAU's existing Authorization for Release of Medical Information form and from the State agencies using a mutually agreed upon release form specific to that agency.

3.2.5 Administration: HEAU will provide other consumer assistance as needed to administer HG § 19-214.4, including referring to the HSCRC or referring potential Consumer Protection Act violations to the Division's enforcement unit.

3.2.6 Data consent form: All parties will respond to HEAU's requests for information that are accompanied by a release form within 10 business days of receipt.

3.3 Other state agencies:

Other state agencies should refer patients and guarantors to the relevant hospital as the primary point of contact for assisting patients and guarantors. The state agencies should also notify patients that HEAU is available to assist eligible patients in obtaining refunds.

3.4 Hospital response to patients not identified as eligible for a refund:

If a patient or guarantor submits a complaint stating that the patient should qualify for a refund under the Reimbursement Law, the hospital should provide a written explanation to the patient or guarantor about why the patient wasn't identified as eligible for a refund and notify the patient or guarantor that the HEAU is available to assist eligible patients in obtaining refunds.

Task 4: Reporting Summary Data to the HSCRC

4.1 In general:

Hospitals, COM, DHS, and WIC/MDH are required to report summary data to the HSCRC.

4.2 Definition:

For purposes of task 4, the term "summary data" has the meaning given that term in the Memorandum of Understanding and the Data Sharing and Nondisclosure Agreement.

4.3 Purpose:

The purpose of the summary data is to allow HSCRC to use the data for the implementation, compliance, and enforcement of HG § 19-214.4. HSCRC will use the summary data for use in presentations, reports, or other communications with the public, including the legislature.

4.4 Data Elements and Data Template:

4.4.1 Reporting Required: Hospitals, COM, DHS, and WIC/MDH must report data elements in the summary data template to HSCRC. The data elements are contained in the summary data template and are listed below.

4.4.1.1. Office of the Comptroller:

At times specified by the HSCRC, COM shall report to the HSCRC, for each hospital, the following data elements:

Item Number	Data Element	Data Description	Format
1	HospID	Hospital Medicare ID	Numeric
2	HospName	Formal Hospital Name	Alpha
3	Service_Year	The year the patient received a service from the hospital that they paid for. Valid entries are 2017, 2018, 2019, 2020, and 2021.	Numeric
4	RecieptDate_COM	The date that COM received the data file from the hospital	MMDDYYYY
5	TotPatRec_COM	By Service_Year, the total number of Maryland patients reported from the hospital	Numeric
6	TotOOPRec_COM	By Service_Year, the total OOP reported from the hospital	Whole dollars
7	TotPatNm_COM	By Service_Year, the total number of patients who did not match to COM data or who matched to COM data, but had incomes greater than 200% FPL (e.g. all patients received from the hospital who were not identified as having incomes at or below 200% FPL).	Numeric
8	TotChgNm_COM	By Service_Year, the total amount of charges reported for patients who did not match to COM data or who matched to COM data, but had incomes greater than 200% FPL (e.g. all patients received from the hospital who were not identified as having incomes at or below 200% FPL).	Whole dollars
9	TotOOPNm_COM	By Service_Year, the total OOP amount reported for patients who did not match to COM data or who matched to COM data, but had incomes greater than 200% FPL (e.g. all patients received from the hospital who were not identified as having incomes at or below 200% FPL).	Whole dollars
10	TotPatMC_COM	By Service_Year, the total number of patients identified as being at or below 200% FPL.	Numeric
11	TotChgMC_COM	By Service_Year, the total charges reported for patients identified as being at or below 200% FPL.	Whole dollars
12	TotOOPMC_COM	By Service_Year, the total OOP amount reported for patients identified as being at or below 200% FPL.	Whole dollars

13	Tot1stLet_COM	By Service_Year, the total number of the first copy of letters sent to patients as a result of the data matching.	Numeric
14	Tot2ndLet_COM	By Service_Year, the total number of the second copy of letters sent to patients as a result of the data matching.	Numeric
15	MatchDate_COM	By Service_Year, the date the data matching was completed for the hospital.	MMDDYYYY
16	LetterDate_COM	By Service_Year, the final date that letters were sent to patients for the hospital	MMDDYYYY
	Calculated fields based on submitted data above		
17	PerPatMC_COM	By Service Year, % of Patients who matched and met criteria for eligibility of all patients received from hospital (Formula: "TotPatMC_COM/TotPatRec_COM").	Percent
18	PerPatMC1stLtr_COM	By Service Year, % of Patients who matched, met criteria for eligibility and were sent the first copy of letters, of all patients that matched (Formula: Tot1stLet_COM/TotPatMC_COM)	Percent
19	PerPatMC2ndLtr_COM	By Service Year, % of Patients who matched, met criteria for eligibility and were sent the second copy of letters, of all patients that matched (Formula: Tot2mdLet_COM/TotPatMC_COM)	Percent
20	PerOOPRef_COM	By Service Year, % of OOP found to be eligible for refunds of all patient OOP (Formula: TotOOPMC_COM/(TotOORec_COM)	Percent

4.4.1.2. Department of Human Services:

At times specified by the HSCRC, DHS shall report to the HSCRC, for each hospital, the following data elements:

Item Number	Data Element	Data Description	Format
1	HospID	Hospital Medicare ID	Numeric
2	HospName	Formal Hospital Name	Alpha
3	Service_Year	The year the patient received a service from the hospital that they paid for. Valid entries are 2017, 2018, 2019, 2020, and 2021.	Numeric
4	RecieptDate_DHS	The date that DHS received the data file from the hospital	MMDDYYYY
5	TotPatRec_DHS	By Service_Year, the total number of Maryland patients reported from the hospital	Numeric
6	TotOOPRec_DHS	By Service_Year, the total OOP reported from the hospital	Whole dollars

7	TotPatNm_DHS	By Service_Year, the total number of patients who did not match to DHS data or who matched to DHS data, but not to WIC (e.g. all patients received from the hospital who were not identified as enrolled in WIC).	Numeric
8	TotChgNm_DHS	By Service_Year, the total amount of charges reported for patients who did not match to DHS data or who matched to DHS data, but not to WIC (e.g. the total charges associated with patients received from the hospital who were not identified as enrolled in WIC).	Whole dollars
9	TotOOPNm_DHS	By Service_Year, the total OOP amount reported for patients who did not match to DHS data or who matched to DHS data, but not to WIC (e.g. the total OOP associated with patients received from the hospital who were not identified as enrolled in WIC).	Whole dollars
10	TotPatMC_DHS	By Service_Year, the total number of patients **identified** as being enrolled in WIC f**or** the year of the date of service. If patients are enrolled in both programs, please count that patient only once.	Numeric
11	TotChgMC_DHS	By Service_Year, the total charges reported for patients **identified** as being enrolled in WIC f**or** the year of the date of service. If patients are enrolled in both programs, please count that patient only once.	Whole dollars
12	TotOOPMC_DHS	By Service_Year, the total OOP amount reported for patients **identified** as being enrolled in WIC f**or** the year of the date of service. If patients are enrolled in both programs, please count that patient only once. If patients are enrolled in both programs, please count that patient only once.	Whole dollars
13	Tot1stLet_DHS	By Service_Year, the total number of the first copy of letters sent to patients as a result of the data matching.	Numeric
14	Tot2ndLet_DHS	By Service_Year, the total number of the second copy of letters sent to patients as a result of the data matching.	Numeric
15	MatchDate_DHS	By Service_Year, the date the data matching was completed for the hospital.	MMDDYYYY
16	LetterDate_DHS	By Service_Year, the final date that letters were sent to patients for the hospital	MMDDYYYY
	Calculated fields based on submitted data above		
17	PerPatMC_DHS	By Service Year, % of Patients who matched and met criteria for eligibility of all patients received from hospital (Formula: "TotPatMC_DHS/TotPatRec_DHS").	Percent
18	PerPatMC1stLtr_DHS	By Service Year, % of Patients who matched, met criteria for eligibility and were sent the first copy of letters, of all patients that matched (Formula: Tot1stLet_DHS/TotPatMC_DHS)	Percent
19	PerPatMC2ndLtr_DHS	By Service Year, % of Patients who matched, met criteria for eligibility and were sent the second copy of letters, of all patients that matched (Formula: Tot2mdLet_DHS/TotPatMC_DHS)	Percent
20	PerOOPRef_DHS	By Service Year, % of OOP found to be eligible for refunds of all patient OOP (Formula: TotOOPMC_DHS/(TotOORec_DHS)	Percent

4.4.1.3. Special Supplemental Nutrition Program for Women, Infants, and Children (MDH)

At times specified by the HSCRC, WIC/MDH shall report to the HSCRC, for each hospital, the following data elements:

i.

Item Number	Data Element	Data Description	Format
1	HospID	Hospital Medicare ID	Numeric
2	HospName	Formal Hospital Name	Alpha
3	Service_Year	The year the patient received a service from the hospital that they paid for. Valid entries are 2017, 2018, 2019, 2020, and 2021.	Numeric
4	RecieptDate_WIC	The date that WIC received the data file from the hospital	MMDDYYYY
5	TotPatRec_WIC	By Service_Year, the total number of Maryland patients reported from the hospital	Numeric
6	TotOOPRec_WIC	By Service_Year, the total OOP reported from the hospital	Whole dollars
7	TotPatNm_WIC	By Service_Year, the total number of patients who did not match to WIC data or who matched to WIC data, but not to WIC (e.g. all patients received from the hospital who were not identified as enrolled in WIC).	Numeric
8	TotChgNm_WIC	By Service_Year, the total amount of charges reported for patients who did not match to WIC data or who matched to WIC data, but not to WIC (e.g. the total charges associated with patients received from the hospital who were not identified as enrolled in WIC).	Whole dollars
9	TotOOPNm_WIC	By Service_Year, the total OOP amount reported for patients who did not match to WIC data or who matched to WIC data, but not to WIC (e.g. the total OOP associated with patients received from the hospital who were not identified as enrolled in WIC).	Whole dollars
10	TotPatMC_WIC	By Service_Year, the total number of patients identified as being enrolled in WIC for the year of the date of service.	Numeric
11	TotChgMC_WIC	By Service_Year, the total charges reported for patients identified as being enrolled in WIC for the year of the date of service.	Whole dollars
12	TotOOPMC_WIC	By Service_Year, the total OOP amount reported for patients identified as being enrolled in WIC for the year of the date of service.	Whole dollars
13	Tot1stLet_WIC	By Service_Year, the total number of the first copy of letters sent to patients as a result of the data matching.	Numeric

14	Tot2ndLet_WIC	By Service_Year, the total number of the second copy of letters sent to patients as a result of the data matching.	Numeric
15	MatchDate_WIC	By Service_Year, the date the data matching was completed for the hospital.	MMDDYYYY
16	LetterDate_WIC	By Service_Year, the final date that letters were sent to patients for the hospital.	MMDDYYYY
	Calculated fields based on submitted data above		
17	PerPatMC_WIC	By Service Year, % of Patients who matched and met criteria for eligibility of all patients received from hospital (Formula: "TotPatMC_WIC/TotPatRec_WIC").	Percent
18	PerPatMC1stLtr_WIC	By Service Year, % of Patients who matched, met criteria for eligibility and were sent the first copy of letters, of all patients that matched (Formula: Tot1stLet_WIC/TotPatMC_WIC)	Percent
19	PerPatMC2ndLtr_WIC	By Service Year, % of Patients who matched, met criteria for eligibility and were sent the second copy of letters, of all patients that matched (Formula: Tot2mdLet_WIC/TotPatMC_WIC)	Percent
20	PerOOPRef_WIC	By Service Year, % of OOP found to be eligible for refunds of all patient OOP (Formula: TotOOPMC_WIC/(TotOORec_WIC)	Percent

4.4.1.4. Hospitals: Hospitals will send summary data to HSCRC at multiple times during the data matching and refund process identified in this SOW.

4.4.1.4.1. Summary of data set sent to COM, DHS, and WIC/MDH: Not later than 30 days after sending a data set to any of the three state agencies, each signatory hospital shall report to the HSCRC, for that hospital and that data set, the following data elements:

Item Number	Data Element	Data Description	Format
1	HospID	Hospital Medicare ID	Numeric
2	HospName	Formal Hospital Name	Alpha
3	Service_Year	Year of Service associated with the service dates for patients included the data file to COM, DHS, and WIC	YYYY
4	DateTrans_COM	The date the data was transferred to the Comptroller.	MMDDYYYY
4	DateTrans_DHS	The date the data was transferred to DHS.	MMDDYYYY
5	DateTrans_WIC	The date the data was transferred to WIC.	MMDDYYYY
6	TotPat_SA	By Service_Year, the total number of patients in the data set sent to COM. This number should be identical to the number sent to DHS and WIC. If it is not identical, the hospital should provide an explanation of the difference to	Numeric

		HSCRC.	
7	TotChg_SA	By Service_Year, the total charges (i.e. the HSCRC regulated rate, including both the amount paid by a third-party payer and the out-of-pocket amount) associated with the patients in the data set sent to COM. This number should be identical to the number sent to DHS and WIC. If it is not identical, the hospital should provide an explanation of the difference to HSCRC.	Whole Dollars
8	TotOOP_SA	By Service_Year, the total OOP amount associated with the patients in the data sent to COM. This number should be identical to the number sent to DHS and WIC. If it is not identical, the hospital should provide an explanation of the difference to HSCRC.	Whole Dollars
9	TotUnqPat	By Service_Year, the total number of unique Maryland patients who were provided services at the hospital in the reported calendar year. This includes patients included in the data set sent to the State agencies and patients excluded from the data set under task 2.1.	Numeric
10	TotChg	By Service_Year, the total charges (i.e. the HSCRC regulated rate, including both the amount paid by a third-party payer and the out-of-pocket amount) associated with all Maryland patients for the hospital for the year. This includes patients included in the data set sent to the State agencies and patients excluded from the data set under task 2.1.	Whole dollars
11	TotOOP	By Service_Year, the total OOP amount associated with all Maryland patients for the hospital for the year. This includes patients included in the data set sent to the State agencies and patients excluded from the data set under task 2.1.	Whole dollars
	Calculated fields based on submitted data above		
12	PerPatSnt	By Service_Year, the % of total patients in the data set sent to hospitals out of all patients (Formula: TotPat_SA/TotUnqPat).	Percent
13	PerChgSnt	By Service_Year, the % of total charges associated with patients in the data set sent to hospitals out of all patients (Formula: TotChg_SA/TotChg).	Percent
14	PerOOPSnt	By Service_Year, the % of OOP associated with patients in the data set sent to hospitals out of all patients (Formula: TotOOP_SA/TotOOP).	Percent

4.4.1.4.2. Patient eligibility: Beginning 60 days after the signatory hospital transfers data to COM, DHS, or WIC/MDH (whichever occurred first), and every 60 days thereafter, the hospitals shall report on the following data elements:

Item Number	Data Element	Data Description	Format
1	HospID	Hospital Medicare ID	Numeric
2	HospName	Formal Hospital Name	Alpha
3	Service_Year	Year of Service associated with the service dates for patients included the data file to COM, DHS, and WIC	YYYY
4	TotPat_SA_AY	By Service_Year, the total number of patients in the data set sent to COM. This number should be identical to the number sent to DHS and WIC. If it is not identical, the hospital should provide an explanation of the difference to HSCRC. (From Hospital a1 template)	Numeric
5	TotChg_SA_AY	By Service_Year, the total charges (i.e. the HSCRC regulated rate, including both the amount paid by a third-party payer and the out-of-pocket amount) associated with the patients in the data set sent to COM. This number should be identical to the number sent to DHS and WIC. If it is not identical, the hospital should provide an explanation of the difference to HSCRC. (from Hospital a1 template)	Whole Dollars
6	TotOOP_SA_AY	By Service Year, the total OOP amount associated with the patients in the data set sent to COM. This number should be identical to the number sent to DHS and WIC. If it is not identical, the hospital should provide an explanation of the difference to HSCRC. (from Hospital a1 template)	Whole Dollars
7	TotUnqPat_AY	By Service Year, the total number of unique Maryland who were provided services at the hospital in the reported calendar year. This includes patients included in the data set sent to the State agencies and patients excluded from the data set under task 2.1. (from Hospital a1 template)	Numeric
8	TotChg_AY	By Service Year, the total charges (i.e. the HSCRC regulated rate, including both the amount paid by a third-party payer and the out-of-pocket amount) associated with all Maryland who were provided services at the hospital in the reported calendar year. This includes patients included in the data set sent to the State agencies and patients excluded from the data set under task 2.1. (from Hospital a1 template)	Whole dollars

9	TotOOP_AY	By Service Year, the total OOP amount associated with all Maryland patients for the hospital who were provided services at the hospital in the reported calendar year. This includes patients included in the data set sent to the State agencies and patients excluded from the data set under task 2.1. (from Hospital a1 template)	Whole dollars
10	TotPatCon_Ltr	By Service Year, the total number of patients who received a letter and contacted the hospital requesting a refund for services in that service year.	Numeric
11	TotChgCon_Ltr	By Service Year, the total charges associated with patients who received a letter and contacted the hospital requesting a refund for services in that service year.	Whole dollars
12	TotOOPCon_Ltr	By Service Year, the total OOP associated with patients who received a letter and contacted the hospital requesting a refund for services in that service year.	Whole dollars
13	TotPatCon_NoLtr	By Service Year, the total number of patients who contacted the hospital requesting a refund for services received in that Service Year, **without a letter from a state agency.**	Numeric
14	TotChgCon_NoLtr	By Service Year, the total charges associated with patients who did not have a letter and contacted the hospital requesting a refund for services in that service year.	Whole dollars
15	TotOOPCon_NoLtr	By Service Year, the total OOP associated with patients who did not have a letter and contacted the hospital requesting a refund for services in that service year.	Whole dollars
16	TotPatDisq	By Service Year, the total number of patients who received letters and contacted the hospital who were disqualified for refunds for services received in that Service Year based on criteria in task 2.8.	Numeric
17	TotChg_Disq	By Service Year, the total charges associated with patients who received letters and contacted the hospital who were disqualified for refunds for services received in that Service Year based on criteria in task 2.8.	Whole Dollars
18	TotOOP_Disq	By Service Year, the total OOP amount associated with patients who received letters and contacted the hospital who were disqualified for refunds for services received in that Service Year based on criteria in task 2.8.	Whole Dollars

19	TotPatDisq_AT	By Service Year, the total number of patients who received letters and contacted the hospital who were disqualified for refunds for services received in that Service Year based on the application of asset tests. This is a subset of the total number of patients disqualified for refunds based on criteria in task 2.8 (#16).	Numeric
20	TotChgDisq_AT	By Service Year, the total charges associated with patients who received letters and contacted the hospital who were disqualified for refunds for services received in that Service Year based on the application of asset tests. This is a subset of the total charges associate with patients disqualified for refunds based on criteria in task 2.8 (#17).	Whole Dollars
21	TotIOOPDisq_AT	By Service Year, the total OOP amount associated with patients who received letters and contacted the hospital who were disqualified for refunds for services received in that Service Year based on the application of asset tests. This is a subset of the total OOP amount associated with patients disqualified for refunds based on criteria in task 2.8 (#18).	Whole Dollars
22	TotPatRef_Let	By Service Year, the total number of patients who received letters and contacted the hospital and were received refunds under task 2.9.	Numeric
23	TotChgRef_Let	By Service Year, the total charges (i.e. the HSCRC regulated rate, including both the amount paid by a third-party payer and the out-of-pocket amount) associated with the patients who received letters and contacted the hospital and who were refunded under task 2.9.	Whole Dollars
24	TotAmtRef_Let	By Service Year, the total amount of the refunds sent to patients who received letters and contacted the hospital under task 2.9.	Whole Dollars
25	LowRefAmt_Let	By Service Year, the lowest refund amount per patient who received letters and contacted the hospital and who was refunded under task 2.9.	Numeric
26	MedRefAmt_Let	By Service Year, the median refund amount per patient who received letters and contacted the hospital and who was refunded under task 2.9.	Numeric
27	AveRefAmt_Let	By Service Year, the average refund amount per patient who received letters and contacted the hospital and who was refunded under task 2.9.	Numeric
28	HighRefAmt_Let	By Service Year, the Highest refund amount per patient who received letters and contacted the hospital and who was refunded under task 2.9.	Numeric
29	TotPatRef_NoLet	By Service Year, the total number of patients with no letter that received refunds.	Numeric

30	TotChgRef_NoLet	By Service Year, the total charges (i.e. the HSCRC regulated rate, including both the amount paid by a third-party payer and the out-of-pocket amount) associated with patients with no letter that received refunds.	Whole Dollars
31	TotAmtRef_NoLet	By Service Year, the total amount of the refunds sent to patients with no letter that received refunds.	Whole Dollars
32	LowRefAmt_NoLet	By Service Year, the lowest refund amount per patient with no letter that received a refund.	Numeric
33	MedRefAmt_NoLet	By Service Year, the median refund amount per patient with no letter that received a refund.	Numeric
34	AveRefAmt_NoLet	By Service Year, the average refund amounts to patients with no letter that received a refund.	Numeric
35	HighRefAmt_NoLet	By Service Year, the Highest refund amount patient with no letter that received a refund.	Numeric
36	*TotPatRedBal*	*The total number of patients with current balances reduced due to the refund amount. This is a subset of the sum of patients refunded in #22 and #29.*	*Numeric*
37	*TotChgRefAmt_Bal*	*The total charges (i.e. the HSCRC regulated rate, including both the amount paid by a third-party payer and the out-of-pocket amount) associated refund amounts applied to current patient balances. This is a subset of the total charges associated with patient refunds under #23 and #30*	*Whole Dollars*
38	*TotRefAmt_Bal*	*The total refund amount applied to current patient balances. This is a subset of the total amount refunded under #24 and #31*	*Whole Dollars*
39	TotRefCk_NC	By Service Year, the number of refund checks that were not cashed before they expired.	Numeric
40	TotPatRefCk_NC	By Service Year, the number of patients/guarantors not provided a refund as a result of the check expiring.	Numeric
41	TotAmtRef_NC	By Service Year, the total amount of refunds not provided as a result of the check expiring.	Whole Dollars
	Calculated fields based on submitted data above		
42	PerPatRef_Snt	By Service Year, total patients who received a refund as a % of all patients sent to COM (Formula: TotPatRef/ TotPat_SA_AY)	Percent
43	PerChgRef_Snt	By Service Year, the total charges associated with patients who received a refund as a % of the total charges for of all patients sent to COM (Formula: TotChgRef/ TotChg_SA_AY)	Percent

44	PerOOPRef_Snt	By Service Year, the OOP associated with patients who received a refund as a percent of the total OOP of all patients sent to COM (Formula: TotOOPRef/ TotOOP_SA_AY)	Percent
45	PerPatRef_All	By Service Year, the total patients who received a refund as a percent of all Maryland Patients (Formula: TotPatRef/ TotUnqPat_AY)	Percent
46	PerChgRef_All	By Service Year, the total charges associated with patients who received a refund as a percent of total charges associated with all Maryland Patients (Formula: TotChgRef/ TotChg_AY)	Percent
47	PerOOPRef_All	By Service Year, the OOP associated with patients who received a refund as a percent of the total OOP for all Maryland Patients (Formula: TotOOPRef/ TotOOP_AY)	Percent
48	PerPatDisq	By Service Year, total patients who had a letter, contacted the hospital, and were disqualified as a % of the total patients who had a letter and contacted the hospital (Formula: TotPatDisq/TotPatCon_Ltr)	Percent
49	PerChgDisq	By Service Year, the charges associated with patients who had a letter, contacted the hospital, and were disqualified as a % of the charges for patients who had a letter and contacted the hospital (Formula: TotChgDisq/TotPatCon_Ltr)	Percent
50	PerOOPDisq	By Service Year, total patients who had a letter, contacted the hospital, and were disqualified as a % of the total patients who had a letter and contacted the hospital (Formula: TotPatDisq/TotPatCon_Ltr)	Percent
51	PerPatRef_Ltr	By Service Year, total patients who received a refund as a % of all patients that contacted the hospital (Formula: TotPatRef_Ltr/ TotPatCon_Ltr)	Percent
52	PerChgRef_Ltr	By Service Year, the total charges associated with patients who received a refund as a % of the total charges for of all patients who contacted the hospital (Formula: TotChgRef_Ltr/ TotChgCon_Ltr)	Percent
53	PerOOPRef_Ltr	By Service Year, the total OOP associated with patients who received a refund as a % of the total OOP for all patients who contacted the hospital. Formula: (TotOOPRef_Ltr/ TotOOPCon_Ltr)	Percent
54	PerPatRef_NoLtr	By Service Year, total patients who received a refund as a % of all patients that contacted the hospital (Formula: TotPatRef_Ltr/ TotPatCon_Ltr)	Percent
55	PerChgRef_NoLtr	By Service Year, the total charges associated with patients who received a refund as a % of the total charges for of all patients who contacted the hospital (Formula: TotChgRef_Ltr/ TotChgCon_Ltr)	Percent

56	PerOOPRef_No Ltr	By Service Year, the total OOP associated with patients who received a refund as a % of the total OOP for all patients who contacted the hospital. Formula: (TotOOPRef_Ltr/ TotOOPCon_Ltr)	Percent

4.4.2. Template:

The HSCRC shall provide each entity with template(s) for submission of summary data to HSCRC that include all required data elements.

4.4.3. Use of summary data: Use of the summary data under Task 4 is subject to the terms of the MOU related to “Use of Summary Data”.

Task 5: Legislative Reporting

5.1 Required report:

The HSCRC will submit a report to the Senate Finance Committee and the House Health and Government Operations Committee, as required by HG § 19-214.4, Maryland Code, on the development and implementation by hospitals of the process to provide refunds to patients under the Reimbursement Law.

5.2 Report is public:

Like other legislative reports, the report in task 5.1 will be publicly available through the legislative library.

5.3 Additional legislative reporting:

Before the 2024 legislative session and the 2026 legislative session, the HSCRC plans to provide a letter to the sponsor of Ch. 310 (2023) and the Committee Chairs of the Senate Finance and House Health and Government Operations Committee to update implementation of the law. The HSCRC will assume that these letters may be made available to the public.

5.4 PII and PHI:

The HSCRC will not include PII or PHI in the report under task 5.1, the letters in task 5.3, or other legislative correspondence. The HSCRC may use the summary data provided under task 4: Reporting Summary Data to the HSCRC in these reports and correspondence.

Task 6: Project Management, Policy Development, Technical Documentation, Technical Assistance to Hospitals and State Agencies

6.1 Project management:

The HSCRC shall provide project management to implement HG § 19-214.4. The HSCRC may work with a contractor to support this project management.

6.2 Policy development:

The HSCRC shall develop necessary policies to implement HG § 19-214.4. The HSCRC will consult with COM, DHS, WIC/MDH, HEAU, and MHA in developing these policies.

6.3 Technical and legal documents:

The HSCRC shall develop technical and legal documents to implement HG § 19-214.4. The HSCRC may delegate development of these documents to other signatories of the MOU and/or to a contractor.

6.4 Technical assistance:

The HSCRC will develop technical assistance to other signatories of the MOU. The HSCRC may delegate this task, in whole or in part, to other signatories of the MOU and/or to a contractor.

Attachment E: Certificate of Data Destruction Template

Please print on Organization Letterhead.

Certification of Data Destruction

I, _____ representing_____

(Name of Custodian) (Name of Organization)

certify that the following data records have been destroyed.

(Please identify names of destroyed files)

The data was destroyed using the following method.

(Please identify destruction method)

This Certificate of Destruction closes the corresponding Data Sharing and Nondisclosure Agreement(s).

(Please identify the DSNA and the organizations that are party to the DSNA)

Organization	
Signature	
Typed Name	
Title	
Date	