Free Hospital Care Refund Process

Required by Health General §19-214.4, MSAR # 14289

Contents

Executive Summary

Health General §19-214.4 requires hospitals to provide refunds to patients who paid for hospital services received in any year between 2017 and 2021 and were eligible, at the time of service, for free care from the hospital under Health General §19-214.1.

To develop the process to provide refunds, HSCRC convened a workgroup that includes all statutorily required stakeholders (the Department of Human Services, the State designated Health Information Exchange, the Office of the Comptroller, and the Maryland Hospital Association) as well as other interested stakeholders. This report also discusses proposed refund process elements based on feedback from the workgroup. The discussion of refund process elements is organized into three sections:

- Statutory requirements for the process to provide refunds and related refund process elements;
- Refund process options; and
- Additional clarifications and rules for the refund process.

The stakeholder workgroup discussed the following policy goals related to the refund process:

- Identifying eligible patients;
- Minimizing the burden on patients by using data from State agencies and hospitals (and, in some scenarios, the State-designated HIE) to identify likely patient eligibility for refunds;
- Providing eligible patients with refunds;
- Protecting the privacy of taxpayers, patients, and beneficiaries of social service benefit programs and minimizing the potential for misuse of data and/or a data breach (some of the process options present significant risks);
- Protecting the privacy of special populations who are particularly sensitive to the exposure of health data, including people experiencing domestic violence;
- Minimizing the burden and cost to hospitals of implementing the requirement to identify patients and provide refunds; and
- Minimizing burden on State agencies to identify patients and monitor the refund process.

Balancing these policy goals is a challenge to developing the process to provide refunds. The stakeholder workgroup discussed four refunds process options, each of which balanced these policy goals differently. The workgroup was not able to reach consensus on a single process.

The Workgroup identified a number of challenges with implementing a refund process. Where legislation could mitigate some of these challenges, this report contains potential legislative language that could be used to address those areas. Legislative changes are required to clarify roles and responsibilities for hospitals, the HIE, and State Agencies and to ensure that all entities involved in the final refund process are compliant with federal and State privacy and data security laws. However, legislative changes are not sufficient to address all of the

challenges discussed in this report. As a result, a policy decision must be made about how to appropriately balance the goal of providing refunds to patients and the risks and challenges with implementing a process to provide those refunds. Due to the challenges described in this report, the refund process has not been developed or implemented.

Introduction

Section 214.4 of title 19 of Health General, Maryland Code (the "refund law") hospitals to provide refunds to individuals who paid for hospital services received in any year between 2017 and 2021 and were eligible, at the time of service, for free care from the hospital under Maryland law relating to hospital financial assistance.[1] The refund law went into effect on July 1, 2022.

A stakeholder workgroup discussed potential elements of the process to provide refunds, including possible options for identifying patients who were due refunds. This report also details proposed process elements, including the challenges presented by some of those process elements. This discussion is organized into three sections:

1. A discussion of each of the statutory requirements for the process to provide refunds.
2. A discussion of four refund process options that were discussed by the stakeholder workgroup.
3. Additional clarifications and rules related to the refund process.

The workgroup identified a number of challenges with implementing a refund process. Some of the challenges to implementing a process to provide refunds can be solved through legislation. In those instances, this report contains legislative language that could be used to address those challenges, as directed by statute.[2]

Stakeholder Consideration of Process

This section describes the stakeholder engagement process for the purpose of developing a process to provide refunds. In the Spring of 2022, HSCRC met individually with DHS, CRISP, the Office of the Comptroller, MHA, and a representative of domestic violence advocates to collect feedback on a possible process, iterating on the process that was described in the introduced version of HB 694 (2022). HSCRC provided a discussion document containing a proposed process to MHA, based on these discussions. In June, MHA reviewed the proposed process with their members and provided feedback to HSCRC.

In August, HSCRC convened a workgroup ("the Workgroup") that includes all statutorily required stakeholders (the Department of Human Services, the State designated Health Information Exchange, the Office of the Comptroller, and the Maryland Hospital Association) as well as other interested stakeholders, including consumer advocates, a representative of domestic violence advocates, representative from a union, and hospital revenue cycle experts. The workgroup met three times between August and November 2022. The first and second workgroup meeting discussed potential processes for providing refunds under the refund law. The November meeting of the workgroup discussed a draft version of this report. For each of

[1] Health General §19-214.1

[2] HSCRC is not taking a position on the legislative language at this time. HSCRC will review any legislation after it is introduced (if that occurs) and determine a position at that time.

the meetings, stakeholders were asked to submit written feedback on a number of topics. The materials for all workgroup meetings are available on the HSCRC website.[3]

Statutory Requirement to Develop a Refund Process

The refund law, which went into effective July 1, 2022, requires HSCRC, Department of Human Services (DHS), the State-Designated Health Information Exchange (HIE)[4], the Office of the Comptroller, and the Maryland Hospital Association (MHA) ("Statutory Reviewers") to develop a process that:

1. Identifies patients who paid for hospitals services who may have qualified for free care under Health General §19–214.1 at the time of care given during calendar years 2017 through 2021;
2. Provides reimbursement to the identified patients, which may be applied incrementally;
3. Ensures that a patient's alternate address is used if the patient requested an alternate address for safety reasons; and
4. Determines how HSCRC, DHS, and the Office of the Comptroller should share and disclose relevant information, including tax information, to the minimum extent necessary to the hospital and in accordance with federal and state confidentiality laws for the purpose of carrying out the required process.[5]

Throughout this report, this process is referred to as the "refund process". This section of the report contains analysis of each of these legal requirements.

Identifying Patients who may have Qualified for Free Care

The refund process must identify "patients …who may have qualified for free care … at the time of care during calendar years 2017 through 2021."[6] This section first describes the law relating to hospital free care that was in effect in 2017 through 2021. Next is a discussion of the data that hospitals use to determine financial assistance followed by a description of the available data sets that could be used to determine whether a patient was likely eligible for free care in 2017 through 2021.

Financial Assistance Law in 2017 to 2021

Since 2005, each hospital in Maryland has been required by law to provide free care to patients at specified income levels under Health General §19-214.1, Maryland Code and COMAR 10.37.10.26 A-2.[7] For the period of 2017 through 2021, Maryland regulations required hospitals

[3] https://hscrc.maryland.gov/Pages/Hospital-Free-Care-Refunds-Workgroup.aspx

[4] The Maryland Health Care Commission designates a HIE as the State-Designated HIE. The current State-designated HIE is CRISP.

[5] HSCRC is allowed to alter the process as necessary (Health General §19-214.4).

[6] Health General §19-214.4.

[7] Chapter 280 (2005). Subsequent amendments to Health General §19-214.1 occurred in 2009 (Chs. 310, 311), 2010 (Chs. 60, 61), 2020 (Ch. 470, § 1), and 2021 (Ch. 769, § 1; Ch. 770, § 1). Hospitals are also required to provide reduced-cost care to patients with specified income levels and amounts of medical debt. HSCRC's regulations related to hospital financial assistance requirements are in COMAR 10.37.10.26 A-2. Non-profit hospitals are also required to

to provide free care to patients at or below 200 percent of the federal poverty level (FPL).[8] Hospitals were also required to determine individuals presumptively eligible for free medical care for patients who were not eligible for Medicaid or CHIP, but were eligible for the following social services programs[9]:

- **Free and reduced cost meals:** The patient lives in a household with children enrolled in the free and reduced cost meal program;
- **SNAP:** The patient receives benefits through the federal supplemental nutrition assistance program;
- **Energy Assistance:** The patient receives benefits through the State's energy assistance program; or
- **WIC:** The patient receives benefits through the federal special supplemental food program for women, infants, and children.[10]

Thus, eligible for hospital free care is based either on family income or the patient's enrollment in one of the programs listed above.

To ensure that patients had notice of the hospital's financial assistance program, hospitals were required to provide patients with information sheets that describe "the hospital's financial assistance policy," and provide contact information "to apply for free and reduced- cost care." Hospitals are required to provide the information sheets to patients before hospital discharge and with the hospital bill. The hospital bill is required to reference the information sheet.[11]

The State has not, at any time, provided data directly to hospitals for the purpose of determining patient eligibility for financial assistance. Hospitals determine patient eligibility based on information provided by patients who apply for financial assistance.[12] HSCRC provides hospitals

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provide financial assistance under Section 501(r)(4) of the federal Internal Revenue Code. This federal law went into effect in 2012.

[8] COMAR 10.37.10.26 A-2. The FPL percentage requirements in that regulation have been the same since at least 2012. Changes were made to COMAR 10.37.10.26 in 2014, 2019 and 2021. In all of those versions 10.37.10.26A-2(2) contained virtually the same language describing the 200% FPL level for free care. In the period between 2017 through September 2020, regulations had a higher FPL level for free care than the Maryland Code. Health General §19-214.1 required that hospitals provide free care to patients with family incomes at or below 150% of the federal poverty level (FPL). Health General §19-214.1 explicitly authorized the HSCRC to set a higher income threshold in regulation ("The Commission by regulation may establish income thresholds higher than those under paragraph (2) of this subsection").Effective October 1, 2020 through the end of calendar year 2021, Health General §19-214.1 required hospitals to provide free care to patients with family incomes at or below 200% of the FPL, matching the preexisting regulatory requirement.

[9] This requirement existed in COMAR 10.37.10.26 A-2 for all of 2017 through 2021. This requirement was added to Health General §19-214.1 in 2020.

[10] The HSCRC and the Maryland Department of Health have the authority under the financial assistance law to designate other social services programs for use for presumptive eligibility for hospital free care. HSCRC and MDH have not designated any other programs for this purpose.

[11] Health General §19-214.1 as in effect between 2010 and 2020. Beginning in 2020, hospitals were also required to provide the information sheet in every written communication to the patient regarding collection of the hospital bill.

[12] Health General §19-214.1. Since 2020, hospitals have been required to use information in their possession, as well as information provided by the patient in the application for financial assistance, to determine the patient's eligibility for financial assistance. The information that HB 694 sought to use for refunds (tax data and SNAP and low-income energy assistance program enrollment data) is not publicly available or shared with the hospitals. For the period from 2017 through September 2020, hospitals were only required to use information provided by the patients through applications for financial assistance to determine patient eligibility for free and reduced cost care.

with a uniform financial assistance application for patients to use to apply for financial assistance.

Available Data Sets Identify Patients who may have Qualified for Free Care

As noted above, a patient qualifies for free care based on income or enrollment in a program that qualifies for presumptive eligibility. The language of Health General §19-214.4 suggests that the legislature may have intended that the refund process use tax data, hospital data from HSCRC, social services benefit data from DHS, patient information from the HIE, and possibly data from hospitals to identify patients who may be eligible for refunds.[13] This section discusses the data sets that are available from these entities and are relevant to identifying patients who may be eligible for refunds.

No single entity named in §19-214.4 can determine with their own data whether an individual qualified for hospital free care. Tax data can determine if the person was eligible based on income. Data from DHS (and MDH and MSDE, which are not named in the law) can determine if a person was enrolled in a program that results in presumptive eligibility for free care. These agencies do not have data on whether or not that individual received a hospital service in a year or if that person paid for the out-of-pocket cost of the service. Data from hospitals is required to identify if the individual was also a patient who paid a bill.

In addition, some hospitals have asset tests as a component of their financial assistance policies and the asset tests vary by hospital. If a hospital denies financial assistance to an otherwise eligible patient due to the legitimate application of an asset test by a hospital, no refund is due to the patient. Hospitals with financial assistance policies that allowed for asset tests between 2017 and 2021 would need to review their records to see if the patient was reviewed for financial assistance and denied based on assets. The Workgroup is not aware of another source of data on patient assets, aside from the patient themselves.[14]

Income Data

Income data is available from two sources: 1) the patient and 2) the Office of the Comptroller, if the patient files taxes.

Patient-provided Income Data

One option for a process to identify individuals who may have qualified for free care is to notify all patients that paid a hospital bill for a service provided between 2017 and 2021 that refunds are available to individuals with incomes under 200% FPL and ask patients who think they qualify to apply to the hospital (see process Option 1 below). This approach will require that the

[13] Health General §19-214.4 states that the refund process will specify "how the Commission, the Department of Human Services, and the Office of the Comptroller should share with or disclose relevant information, including tax information, to the minimum extent necessary to the hospital… for the purpose of carrying out the process" for providing refunds.

[14] Neither the Office of the Comptroller nor DHS has complete information on patient assets.

patients provide income or program enrollment data to the hospitals, just as they would have had to do if they had applied for financial assistance in the 2017 through 2021 time period.

Income Data from the Office of the Comptroller

The Office of the Comptroller has income data for all tax filers in Maryland. Income tax data from the Office of the Comptroller could be used to identify individuals with incomes at or below 200 percent FPL.[15] This data is only available for households that filed taxes. Maryland does not require tax filing for households with very low incomes. For example, individuals with incomes under $10,400 in were not required to file a Maryland income tax return in 2017. The FPL in 2017 was $12,060 for an individual. The minimum filing requirement has increased each year; for 2020, individuals with income under $12,550 were not required to file (2020 FPL for an individual was $12,760). It is not clear how much this missing data will impact the refund process, as most individuals with incomes below the poverty line should qualify for Medicaid rather than hospital free care.

Tax data is personally identifiable information that is subject to strong privacy protections.[16] Under the Tax General Article of the Maryland Code, tax data[17] may only be shared with a select list of State agencies for limited uses. All but three exceptions[18] to the prohibition against disclosure is related to the Comptroller's prerogative to administer the tax law. Tax General has no current exceptions that permit disclosure to a non-governmental entity. Thus, the sharing of tax data with hospitals, which is a component of some of the refund process options discussed below, would represent a significant change in policy with respect to the use of tax data. Additional concerns related to data sharing are discussed later in this report.

If tax data is necessary for the process to provide refunds, the following amendment to Maryland law would clarify that use of tax data for this purpose is permissible:

In Tax General §13-203(c), strike "and" at the end of paragraph (12)(ii); strike the period at the end of paragraph (13) and insert "; and"; and insert the following:

(14) a hospital, the Commission, the Department of Human Services, and the State-Designated Health Information Exchange for purposes of Health General §19-214.4.

[15] Note that for 2017, individuals with income under $10,400 were not required to file a Maryland income tax return. The minimum filing requirement has increased each year; for 2020, individuals with income under $12,550 were not required to file. The Office of the Comptroller's data may not include a large swath of patients who qualify for free care because those patients may not have filed a tax return.

[16] Tax General §13-203 lists the entities and individuals that tax data can be shared with under Maryland law.

[17] "Tax information," with respect to income tax, includes "the amount of income or any other particulars disclosed in a return." Tax General §13-201(1).

[18] TG §13-203(11) permits disclosure to the Maryland 9-1-1 Board; § 13-203(8) permits disclosure to the Maryland Department of Health in accordance with the federal Children's Health Insurance Program Reauthorization Act of 2009; § TG 13-203(13) permits disclosure to the Maryland Higher Education Commission.

This amendment would likely result in a joint referral of the legislation to the legislative committees with jurisdiction over tax law, in addition to the committees with jurisdiction over health law. A joint referral would ensure that legislative staff and members with expertise in Maryland tax law will review the tax data privacy issues raised by this amendment.

Using tax data to determine eligibility for hospital refunds would create precedent for using tax data for determining eligibility for hospital financial assistance on an ongoing basis, which would require additional resources to be allocated to the Office of the Comptroller. If additional resources were not provided, this project would require the use of resources that would otherwise be used to ensure efficient revenue collection.[19]

Data related to Presumptive Eligibility for Free Care

Individuals are presumptively eligible for hospital free care if they are enrolled in any of the following programs:

- **Free and reduced cost meals:** The patient lives in a household with children enrolled in the free and reduced cost meal program;
- **SNAP:** The patient receives benefits through the federal supplemental nutrition assistance program;
- **Energy Assistance:** The patient receives benefits through the State's energy assistance program; or
- **WIC:** The patient receives benefits through the federal special supplemental food program for women, infants, and children.[20]

The Departments that administer these programs maintain data on program enrollment.

DHS Programs: SNAP and Energy Assistance

The Department of Human Services administers the SNAP and Energy Assistance Programs. DHS data could be used to determine if individuals were enrolled in those programs in a year, for the purpose of determining if an individual was presumptively eligible for hospital free care.

Free and Reduced Cost Meals

The Free and Reduced Cost Meals program in Maryland is administered by the Maryland State Department of Education (MSDE) and is not mentioned in the refund law. As a result, there is no legal authority to include data on free and reduced meals program enrollment in the refund process, even though families in these programs are presumptively eligible for free care. If the legislature would like free and reduced cost meal program enrollment data to be included in the refund process, the legislature should amend Health General §19–214.4 to allow inclusion of this data. Including this data would add complexity to the refund process, increase risks related

[19] Maryland law on medical debt and financial assistance changed in 2021. Ch. 769, § 1; Ch. 770, § 1. However, the process for determining patient eligibility for financial assistance did not change (i.e. that a patient must apply and provide income information and/or a hospital must use publicly available information)

[20] HSCRC and MDH have the authority, in the financial assistance statute (Health General §19–214.1), to designate other social services programs for inclusion in the hospital free care presumptive eligibility requirements. Neither State agency has expanded this list of social services programs has not been expanded by either State agency.

to data privacy and security, and increase administrative costs for State Agencies. In addition, student data is subject to additional privacy laws that are not analyzed for this report, but which would need to be considered if MSDE data was used.[21]

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program in Maryland is administered by the Maryland Department of Health (MDH). Similar to MSDE, MDH is not mentioned in the refund law. As a result, there is no legal authority to include data on free and reduced meals program enrollment in the refund process, even though families in these programs are presumptively eligible for free care. If the legislature would like data on WIC enrollment to be included in the refund process, the legislature should amend Health General §19–214.4 to allow inclusion of this data. Including this data in the refund process would add complexity, increase risks related to data privacy and security, and increase administrative costs for State Agencies.

Identifying Patients who Paid for Hospital Services

In addition to identifying if a patient was eligible for free hospital care based on income or social service enrollment, the refund process must also identify if the patient paid an out-of-pocket amount for a hospital bill for a hospital service with a date of service between 2017 and 2021.[22] There are two possible sources of this data: 1) HSCRC data analysis on patient cost share and 2) patient payment data maintained by hospitals.

HSCRC Data Analysis on Patient Cost Share

The HSCRC can conduct an analysis using UCC write off data (i.e., data provided by hospitals to HSCRC on charity care and bad debt data), cost share values provided in the Medical Care Data Base (MCDB), and known benefit design elements (e.g. Medicaid has no cost share in Maryland) to impute the cost share owed by categories of patients (one category was Medicaid eligibles) and estimate total out-of-pocket costs paid. HSCRC cannot determine the exact amount that each patient paid for hospital visits based on this analysis. [23]

The usefulness of this data is also limited because it does not include whether or not an insurer denied the charge for the service. If the insurer denied the charge, in most instances, there is no cost sharing for the patient. HSCRC's data is based on what the hospital will charge the insurer

[21] For example, the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) likely applies to this data.

[22] Health General §19-214.4 requires that HSCRC develop a process that "identifies patients who paid for hospital services…under Health General §19–214.1 at the time of care during calendar years 2017 through 2021."

[23] HSCRC estimates that the out-of-pocket amount for individuals who may be due refunds in 2017 and 2018 amounts to about $400 per unique patient for the 2-year period combined. HSCRC expects that there is significant variation in the OOP amount by patient. Based on HSCRC analysis and subject to multiple assumptions and limitations, this amount is likely higher for individuals with incomes that are known (through tax data) to have incomes at or below 200% FPL and lower (approximately $300/person for both years) for individuals with no known income in the year of the hospital service.

at the time of discharge. Thus, HSCRC cannot definitively say if the patient is entitled to a refund. Denials by insurers should be accounted for in the refund process, to ensure that refunds only go to patients who paid an out-of-pocket amount.

This analysis includes data from the MCDB, which is owned by the Maryland Health Care Commission (MHCC). MHCC is not mentioned in the refund law. Including this data in the refund process would add complexity, increase risks related to data privacy and security, and increase administrative costs for State Agencies.

Hospital Data on Patient Payments

The most accurate source of data on whether a patient paid any out-of-pocket amount on a bill and the amount of the payment is the hospital. Even if the process used HSCRC data analysis to identify patients who may have paid a bill, ultimately the hospital would need to confirm that payment and the amount paid before issuing a refund. Given the limitations of HSCRC data analysis, hospital data should be used to determine if a patient paid an out-of-pocket cost instead of HSCRC data on charges. Hospitals will need to expend resources (particularly staff time) on the data analysis required to identify the amount paid out-of-pocket by patients.

Providing Reimbursement to Patients

Once a patient has been identified as eligible for a refund, the refund process must include steps to provide that patient with a refund. Under the refund process, hospitals will provide reimbursement directly to the patients after the hospital confirms 1) that the patient was eligible for free care for a service that was provided between 2017 and 2021, and 2) the amount that the patient paid.

The refund law allows for the refund process to be "applied incrementally."[24] Incremental implementation of the process will allow for refinements in the process over time and will help manage the administrative burden of the process on hospitals and State agencies.[25] The State agencies will monitor the results of the initial implementation and change any subsequent implementation based on lessons learned from the initial implementation.

The introduced version of HB 694 (2022) contained a triggering condition that allowed the process to be canceled if the outcome from the initial implementation of the refund process was insufficient. Health General § 214.4 does not contain a triggering condition. Adding a provision to Health General § 214.4 that allows cancellation of the process would be reasonable if the process does not result in meaningful benefits to patients.

Potential Legislative Amendment to Health General § 214.4:

[24] Health General §19-214.4

[25] If process Option 1, discussed below, is the final process, the process will first be implemented for dates of service in 2021, as that is the most recent year and patients applying for refunds will be likely to have the necessary data easily accessible. If the process option that is selected allows for the reuse of any analysis done for the 2020 refund report (see appendix), it would be reasonable to start with 2017-2018, the period covered by that analysis.

Strike “The Commission may modify the process developed subsection (a) of this section as necessary” and insert
“**(1) The Commission may modify the process developed under subsection (a) as necessary.**
(2) If less than 10 percent of the estimated refunds are made each year in the first increment of the process developed under this section, implementation of additional increments of the process is not required.”

Legislative language that requires entities involved in the refund process to report information on the implementation of the process to HSCRC is necessary to allow HSCRC to monitor the refund process. This reporting requirement is particularly important if the trigger condition is added to law, so that HSCRC has the information necessary to determine if the trigger was met. This language will also ensure that HSCRC has the information that is necessary to include in the reports to the General Assembly that are required by the refund law.

Potential Legislative Amendment to Health General § 214.4 to require entities to report information to HSCRC on the refund process:

After “(c)” insert **“The Department of Human Services, the Office of the Comptroller, the State-Designated Health Information Exchange, and the Hospitals shall report information on the process under this section the Commission in such time and manner as determined by the Commission.**
(d)”

The specific data elements required will depend on the process option that is used to provide refunds. If the refund process that is implemented does not require data from all of the entities listed in the amendment above, the reporting requirement above should be simplified by removing these entities from the amendment above.

Safe Addresses and Electronic Delivery of Information

At some point in the refund process, patients will receive a notice that they may be eligible for a refund. The refund law requires “that a patient’s alternate address is used if the patient requested an alternate address for safety reasons.”[26] All of the refund process options discussed later in this report involve contacting patients about past health services, which raises concerns for advocates who represent people who have experienced domestic violence, as inadvertent disclosure of past health services could increase danger for these individuals. The language about safe addresses was added to the law to minimize the risk that the letters (or other communications) sent to patients would endanger patients who experience domestic violence or have other reasons to be particularly sensitive to exposure of their health information to household members (for example, adolescents seeking sexual health services) if those household members opened the mail.

[26] Health General §19-214.4

Only Hospitals have Safe Addresses

"Safe addresses" are provided by the patient to the hospital and hospitals are the only source of safe addresses. These addresses are not in any State agency databases. The way in which hospitals flag safe addresses in their databases varies by hospital and is dependent on the processes they have established to care for patients with sensitive needs (such as assault, sexually transmitted infections, substance abuse, behavioral health, etc.). If the hospital does not have a safe address on file, the next best address, for safety purposes, is the current mailing address for the patient that is on file with the hospitals.

For the process options (discussed below) that use data from State Agencies to identify patients, hospitals must either: 1) share addresses for a broad set of patients with State agencies to allow State Agencies to use the hospital addresses to contact patients or 2) State Agencies must share personally identifiable state data (including tax data) with hospitals, to allow the hospitals to know which patients should be contacted. Both approaches require careful consideration of federal and state laws related to patient privacy and information security.

Method for Contacting Patients

The statutory language related to safe addresses assumes that patients will be contacted through physical mailed letters.[27] The workgroup discussed whether electronic delivery of information to patients might be safer for these patients, rather than paper letters. The concern was that a mailed paper letter had a higher risk of being opened by another person in the household, compared to information that was delivered through an electronic method. Options for electronic delivery of information include hospital patient portals or emails. Text messages are also an option.

Hospital patient portals are the best approach to minimize unauthorized access to communications about refunds, compared to emails and paper letters. These secure portals are specifically designed to comply with federal data privacy standards, which are discussed in more detail below.[28] The refund process should, if possible, deliver information about refunds to patients via the hospital's patient portal. Approximately 60 percent of hospital patients have opted to receive hospital communications electronically through secure patient portals or text messages. The patients that use these internet portals may have higher education and/or income levels than the patients that do not use these portals, so the use rate among individuals who are eligible for refunds is likely lower than 60 percent. Thus, another method will need to be used to contact patients who do not use the hospital patient portal.

[27] The introduced version of the bill required the use of postcards to contact patients. Due to privacy concerns, the Assistant Attorney General for the General Assembly determined that letters should be required, not postcards, so that all the private information was inside an envelope.

[28] Specifically, these portals are designed to be compliant with the federal Health Insurance Portability and Accountability Act of 1996.

Emails are another method for contacting patients. Hospitals have email addresses for some, but not all, patients. Emails pose a moderate risk that, in the case of domestic abuse, the email address is shared in the household. Text messages have a similar risk.

Content of Messages to Patients

The risk to patient safety posed by a communication to patients depends, in part, on the content of that communication. For example, if a letter to a patient contains details of an ED visit that the patient had hidden from an abuser, that letter could generate a risk to patient safety. This topic generated discussion in the stakeholder workgroup. For the purpose of protecting patient safety, communications (particularly letters and emails) that are vague about the details of the patient's encounter with the hospital are better. Domestic violence advocates requested that letters not include the date the hospital service was provided, for example. On the other hand, including the date of service (or year) and the hospital name will assist the patient in understanding the refund process. No information in the type of service received or the patient's diagnosis should be included in the communication- this is not necessary.

To prompt higher response rates, letters should provide patients with clear notice that they may be entitled to a refund. The communication should incorporate best practices in health literacy to ensure that consumers understand the communication. The stakeholder workgroup will continue to work to define the content of the communication to patients. Because this discussion is ongoing, the text of the initial communication to patients about the refunds should not be included in law.

Minimizing Data Sharing and Complying with Confidentiality Laws

The final statutory requirement for the refund process is that it must minimize data sharing and ensure that the data is used in compliance with federal and state "confidentiality" laws.[29]
The stakeholder workgroup discussed four options for the process to determine and provide patients with refunds for free care. These process options are described in more detail later in the report. This section of the report discusses privacy and data security issues that apply to all or some of the refund process options, including federal and state privacy and data security laws.

Three of the process options involve extensive data exchange between multiple entities, including State Agencies and hospitals. Each exchange of data between entities, and each additional entity that has access to data, increases the risk that data will be mishandled or breached. This is a serious data security concern.

[29] Health General §19-214.4 requires that the refund process specify that "how HSCRC, DHS, and the Office of the Comptroller should share and disclose relevant information, including tax information, to the minimum extent necessary to the hospital and in accordance with federal and state confidentiality laws for the purpose of carrying out the required process."

MOUs and DUAs to ensure Minimal Data Sharing and Data Destruction

If the refund process to provide hospital refunds requires data sharing between State Agencies, the State Agencies (and the State Designated HIE) that are sharing data with each other will enter into a joint memorandum of understanding (MOU). This MOU will describe the data to be shared, how that data will be stored and transferred by each agency (to ensure the privacy and security of the data), how the data will be used (to ensure it is only used for the purpose of Health General §19-214), clarify obligations and liability with respect to data misuse or data breach, and when and how the data will be destroyed, if applicable. This MOU will ensure that data is used solely for the purpose of the process for providing refunds; that it is shared to the minimum extent necessary for that purpose; and that it is destroyed when it is no longer needed. This MOU is only necessary if State agency data is needed. The addition of statutory language requiring a MOU between the State agencies and the HIE would memorialize this approach, but this statutory change is not necessary as State agencies are committed to this approach.

Each entity that is sharing data for the process to provide refunds to patients will need to enter a Data Use Agreement that contains similar information to the MOU. If data is being shared between State Agencies, the HIE, and hospitals, these DUAs will have to be agreed to by the 46 non-profit hospitals in the State, in addition to the three State Agencies and the HIE. This process will take time, as legal counsel at each hospital will want to review these documents. No DUAs are required if the process only involves hospitals sharing data with patients (see the description of process Option 1 below) with no data sharing by State Agencies or the HIE.

Compliance with Federal Privacy and Security Laws

A number of federal laws relate to the sharing of personally identifiable health information. Below is a description of the most relevant Federal laws. This report does not assert that these are the only federal laws related to data sharing and data privacy that may impact the refund process.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets requirements for health information security and privacy. HIPAA sets national standards for the privacy of medical records and other individually identifiable health information (referred to as "protected health information" or PHI).[30] HIPAA also sets standards for protecting certain health information that is held or transferred in electronic form (e-PHI). HIPAA protects "all individually identifiable health information a covered entity creates, receives, maintains or transmits in electronic form."[31] Under this law, HIPAA covered entities must protect the "confidentiality, integrity, and availability of all e-PHI they create, receive, maintain, or transmit" and protect against reasonably anticipated threats to the security of the data and reasonably anticipated impermissible disclosure of the data.

[30] https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
[31] https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

HIPAA applies to “covered entities,” such as hospitals and other health care providers, and the “business associates” acting on behalf of the covered entities (such as the State-Designated HIE). Under HIPAA, PHI is permitted to be disclosed to the HSCRC as a health “oversight agency.” The Office of the Comptroller and the Department of Human Services are not subject to HIPAA.

Disclosure of data by hospitals and the HIE for the process to provide refunds would be allowable under HIPAA if: 1) the data sharing is required by law;[32] or 2) an oversight agency requires the protected health information for oversight activities authorized by law.[33] The refund law does not currently require hospitals or the HIE to share data for the purpose of the process to provide refunds. Adding clear and specific language to the refund law to require the hospitals and the HIE to share the data required by this process will ensure that this data sharing is compliant with HIPAA (see below for legislative language).[34]

Substance Use Treatment Data

The federal regulations in Part 2 of Title 42 of the Code of Federal Regulations cover patient data related to substance use treatment services from federally assisted programs. 42 CFR Part 2 is more protective of patient privacy than HIPAA. The information protected by 42 CFR Part 2 cannot be shared for the purposes of providing refunds without the explicit written consent of the patient. For that reason, the refund process will exclude data protected by 42 CFR Part 2 from the process to provide refunds if hospitals will be required to share data with other entities (not including patients). This means that hospital patients who sought substance abuse treatment and are due a refund would not be contacted through any refund process that requires data sharing of information that is protected by this federal regulation.

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[32] According to HIPPA, "required by law" means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits."

[33] Under HIPAA (45 CFR 164.502(j)(1)(ii)(A)), a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:
(i) The health care system;
(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;
(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or
(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

[34] An alternative approach would be for HSCRC, as a health oversight agency, to require the hospitals and HIE to share data for the purpose of the process to provide refunds. HSCRC would prefer that this requirement be in law.

Compliance with State Laws and Regulations

In addition to the federal laws described above, entities involved in sharing personally identifiable health information must also comply with applicable state laws. Below is a description of some of the most relevant state laws. This report does not assert that these are the only state laws related to data sharing and data privacy that may impact the refund process.

The Maryland Medical Records Act

The Maryland Medical Records Act allows a healthcare provider to disclose medical records to a government agency performing its lawful duties as authorized by an act of the General Assembly without the authorization of the patient, subject to limitations for mental health service records.[35] If the refund process requires hospitals to share patient information with other entities, including State Agencies, the addition of clear language to Health General §19-214.4 requiring the hospitals to share this data for this specific purpose would ensure that this data sharing is in compliance with the Maryland Medical Records Act (see below for legislative language).

HIE regulations

The State-designated HIE is subject to specific privacy requirements (Health-General §4-302.2; COMAR 10.25.18). The State-Designated HIE may only disclose potentially identifiable information to an "authorized user" for uses that are consistent with state and federal law.[36] Health General §19-214.4 does not mention the HIE in the language related to data sharing. If the process that is developed to provide refunds requires the HIE to participate, the addition of clear language to Health General §19-214.4 authorizing the HIE to share data would mean that the use of the data was "required or permitted by law," allowing the HIE to participate in the process and remain in compliance with existing State regulations (see below for legislative language).

Authorization of Data Sharing

While the existing language in the refund law implies that this data sharing is required[37], adding a requirement to the law to explicitly authorize data sharing between all entities involved in the refund process will add clarity to the law to ensure compliance with privacy and security laws (including HIPAA) and agency authorizing statutes. Note that the suggested statutory change below names all entities that could be involved in sharing data. This language could be narrowed to exclude entities that are not required in the final refund process.

[35] Health General §4-305(b)(3). The limitations related to mental health service records are in Health General §4-307(c).
[36] COMAR 10.25.18. The Maryland Health Care Commission (MHCC) regulates the HIE.
[37] The refund process must specify "how the Commission, the Department of Human Services, and the Office of the Comptroller ***should*** share with or disclose relevant information…to the hospital" (emphasis added). Health General §19-214.4.

If the process used to provide refunds requires data sharing, the following amendment to Health General §19-214.4 would ensure that hospitals, the HIE, and State agencies had authority to share data for the purpose of providing refunds:

> After "(c)" insert **"Notwithstanding any other provisions in law, the Commission, the Department of Human Services, the State Designated Health Information Exchange, the Office of the Comptroller, and hospitals may share or disclose with each other, to the minimum extent necessary, relevant information necessary for implementation of the process developed under subsection (a) of this section. (d) "**

If the HIE is necessary for the process to provide refunds, the following amendment to Health General §19-214.4(a)(4) would further clarify the HIE's role in the process:

> In subsection (b)(4), "and the Office of the Comptroller" and insert "**the Office of the Comptroller, and the State-Designated Health Information Exchange".**

Discussion of Process Options

The workgroup considered four refund process options. These options use different data sources and different data flows. A key challenge in developing the process to provide refunds is balancing the following policy goals:

- Identifying eligible patients.
- Providing eligible patients with refunds.
- Protecting the privacy of taxpayers, patients, and social service benefit programs. beneficiaries, including minimizing the potential for misuse of data and/or a data breach.
- Protecting the privacy of domestic violence survivors and other special populations who are particularly sensitive to the exposure of health data.
- Minimizing the burden on patients who may be eligible for refunds by using data from State agencies and hospitals (and, in some scenarios, the State-designated HIE) to identify likely eligible patients.
- Minimizing the burden and cost to hospitals, which are experiencing a workforce shortage.
- Minimizing burden on State agencies.

Each of the four process options balances the policy goals above differently. This section describes each process option and analyzes them relative to the policy goals. Table X, at the end of this section, succinctly compares the process options based on both statutorily required process elements and other policy goals listed above.

The stakeholder workgroup discussed all of these options and there was no consensus on a process option. Other process options are likely possible, however, given the complexity of this issue, only the four options described below were discussed as reasonable options.

Option 1: Hospital and Patient-provided Data Only

Under Option 1, hospitals will review their billing data and identify all patients who paid for any out-of-pocket cost for a hospital service provided between 2017 and 2021. Hospitals would contact the patients who paid for a service in that time period, using the process for contacting patients discussed earlier in the report. If the patient responds to the initial communication from the hospitals, the patient will provide the hospital with any additional information that is needed to determine if the patient was eligible for a refund. This process closely resembles the process used to provide financial assistance to patients, where hospitals provide notice to the patients through the required information sheet and patients apply for the financial assistance.

Potential Benefits

Because this refund process option does not use data from State Agencies or the HIE, this process mitigates many of the data privacy and data security issues raised by the other process options discussed below. The only data used to contact the patient is from the hospital's patient records and that data is only shared with the patient, not with any other entity. Under this option, there is no risk of a data breach of sensitive State data. Additionally, concerns about disclosing individual tax data and program enrollment data without the patient's permission are reduced because the patient is providing this information directly to the hospital under this option, thereby consenting to the use of this data for the purpose of determining their eligibility for a refund. This option also reduces State Agency and HIE administrative burden and cost.

In addition, this process will result in all potentially eligible patients being contacted about the refunds. In the other processes, some eligible patients will be missed because of the data matching processes.

Potential Risks

Under refund process Option 1, all patients who paid for a hospital service provided in this time period will be contacted, regardless of family income or social services program participation. This will result in a significant number of patients being contacted who will not be eligible for refunds. This may increase the burden on hospitals to answer patient questions about the refund process, resulting in increased hospital expenses. This option will also increase the burden on hospitals for determining refund eligibility as hospitals will not be able to rely on State agency data as de facto evidence of income or social services program eligibility.

This option also increases the burden on patients to provide information to the hospitals on their eligibility in 2017 through 2021, compared to refund process options that use tax data and DHS social service program enrollment data as de facto evidence of eligibility for free care based on income or program enrollment. Patients will have to submit information similar to the information that is required on a financial assistance application. This may be challenging for patients who have retained income or program enrollment documentation from this time period, resulting in these patients not receiving refunds although they may be eligible for the refunds.

Option 2: Start with Tax Data

Under Option 2, the process to identify patients eligible for refunds would start with the Office of the Comptroller. Tax data would be combined with data from the HIE, HSCRC data analysis (described above), and DHS program enrollment data to further reduce the pool of patients who may be eligible for refunds. The combined dataset would then be shared with the hospitals to contact patients. This process is based on the process that was used in the introduced version of House Bill 694 (2022) but has been updated to reflect input from stakeholders.

First, the Office of the Comptroller will use tax data from tax years 2017 through 2021 to households with incomes at or below 200 percent FPL in FY 2019 through 2021 (this process has already been completed for 2017 and 2018). This data set will include all individuals who met this income criteria without regard for whether these individuals had a hospital service in the year or paid for a hospital bill. This means that data for individuals who do not qualify for a refund because they did not pay an out-of-pocket amount for a hospital service will be shared, even though these individuals will not benefit from the refund process.

The Office of the Comptroller will send identifiable data for all individuals who met the income criteria to the HIE. This data set from the Office of the Comptroller, at a minimum, will contain name, address (from the tax data), the unique id number used by the Office of the Comptroller to identify individuals, and other data elements that will be specified in the final refund process to enable data matching. The HIE will match this data to the master patient index (an index of patients whose data has passed through the HIE) and create two data sets containing:

1) A list of the HIE's enterprise ID numbers (EIDs) for taxpayers with incomes at or below 200 percent FPL who are also in the HIE's patient index. This data set will be shared with HSCRC for each tax year. No other data will be in this list. Because this list is for people with a specified FPL range, the Office of the Comptroller considers this list to be tax data, and therefore sensitive information.
2) A crosswalk of the Office of the Comptroller's user ID and the HIE's EID. This crosswalk will be shared with the Office of the Comptroller.

The HIE will destroy the identifiable tax data that was shared by the Office of the Comptroller, subject to timing determined in the data use agreement. Some portion of the individuals in the data set shared by the Office of the Comptroller will not match with the HIE's master patient index because their data is not in the HIE. If the individual's data is not in the HIE it is unlikely that the individual had a qualifying hospital service. Another reason for mismatches could be the result of differing identification information at the Office of the Comptroller vs the data held by the HIE (for example a different address or phone number). Free care eligibility for individuals whose tax data does not match the HIE data eligibility will be based on social service program enrollment later in the process.

The HSCRC will use the list of HIE EIDS, HSCRC's case mix (hospital discharge) data set to identify two groups of patients:

1) **Patients with known income:** Patients who received a hospital service in 2017 through 2022 and had an income at or below 200 percent FPL (from the tax data).
2) **Patients without a known income:** Patients who received a hospital service in 2017 through 2022 and did not have a known income at or below 200 percent FPL.

HSCRC's case mix data set has the HIE's EIDs but has no other identifying information that can be linked to the Office of the Comptroller's data (e.g., names, addresses, phone numbers). Thus, HSCRC cannot reidentify the patients in the list provided by the HIE.

HSCRC would send a data set containing patients with an income at or below 200 percent FPL who received a hospital service for each year (2017 through 2021) to each hospital, for patients of that hospital. The dataset would include medical record numbers, patient account numbers, dates of service, and other variables that enable hospitals to match the identified patients to service dates in their electronic health records (EHR).

The hospital will use the HIE/HSCRC linked data to review their records to determine if the patient actually paid an out-of-pocket cost for the service. If the patient paid a bill, the hospital would identify the patient's current contact information (including safe address, if available) in their data. The hospital will then contact the patients who paid a bill to inform them that they may be due a refund. At the patient's request, the hospital would determine if the patient was eligible for free care and, if so, provide a refund.

HSCRC will provide the dataset for patients without a known income who received a hospital service in 2017 through 2022 to the HIE. In addition, DHS will send a data set to the HIE that contains, at a minimum, name, address, SNAP or Energy Assistance enrollment dates, and other specified data elements to allow for data matching.

The HIE will use the EID in the data set provided by HSCRC to create an identifiable data set for all patients who received a hospital service in 2017 through 2022, may have paid a hospital bill for that service, but did not have a known income at or below 200 percent FPL. This data set will contain name, address, hospital, the date of the hospital service, and other specified data elements to allow for matching to an identifiable data set containing enrollees in SNAP and Energy Assistance from the Department of Human Services (DHS). The HIE will match this data set with the data from DHS to identify patients who received a hospital service in 2017 through 2022 and did not have a known income at or below 200 percent but are likely eligible for free care based on presumptive eligibility due to enrollment in SNAP or the Energy Assistance. Mismatches between the HIE and DHS datasets may be the result of the social service program enrollee not having a hospital visit in this time period or the data shared by DHS is different than the data that the HIE has on that same individual (for example a different address or phone number). The HIE will destroy the data for DHS program enrollees who do not match subject to timing determined in the data use agreement.

The HIE will share the combined HSCRC/DHS data set with hospitals. This data set contains identifiable information about patients who received services at that hospital in 2017 through

2022 and were enrolled in SNAP or Energy Assistance. Each hospital will apply the same process with this group of patients as it did with the patients with known income described above.

Potential Benefits

This refund process option reduces burden on patients and hospitals compared to Option 1 by using state data to identify individuals who may be eligible for refunds.

Potential Risks

This option raises significant concerns about the privacy and security of tax data, concerns that are accentuated as tax data is shared with the HIE, HSCRC, and hospitals without taxpayer consent. Other sensitive data (including all patient visits for whom income is not known and DHS program data) would be shared with the HIE to determine eligibility for a refund. Many of the Individuals in these data sets ultimately may not benefit from this process, but the process puts their data at risk. For example, individuals who are identified by DHS as being enrolled in in SNAP and Energy Assistance, there are concerns about the data being overinclusive for purposes of providing refunds, in that some number of program enrollees will not have had (or paid for) a hospital service in this time period and their identifiable information is being shared with the HIE without their consent.

Finally, this option has a high number of data transfers and thus presents a high risk for a data breach. This option puts a relatively high burden on State Agencies, compared with Option 1.

Option 3: Start with Hospital Data

Under Option 3, the process starts with data from hospitals on patients who paid bills for services in the time period and would include the patient's safe address (or, if the safe address is not available, the patient's current address). This data would be combined with data from the Office of the Comptroller and DHS to identify patients who may be eligible for refunds for hospital financial assistance.

First, hospitals would identify all patients who paid an out-of-pocket expense for dates of service between 2017 and 2021. Each hospital will share an identifiable data set with the Office of the Comptroller that contains, for each patient, name, address in the year of the date of service, current safe address (or current address, if there is no safe address), hospital name, the date of the hospital service, and other specified data elements specified to allow for data matching.

The Office of the Comptroller would match the hospital data with tax data and identify patients who received hospital services, paid out-of-pocket costs, and were at or below 200 percent FPL during the year of the service dates. After this matching process, the Office of the Comptroller would:

- send letters to those patients who were identified as having incomes at or below 200 percent FPL, using the current safe address (or current address, if there is no safe address) from the hospital.
- destroy data received from hospitals for patients over 200 percent FPL, as these patients likely do not qualify for free hospital care; and
- share with DHS, identifiable data for patients that did not match to tax data that would contain, for each patient, name, address in the year of the date of service, current safe address (or current address from the hospital, if there is no safe address), hospital name, the date of the hospital service, and other specified data elements specified to allow for data matching.

The DHS would use the hospital data shared by the Office of the Comptroller for patients who paid a bill but did not match to tax data to match with enrollees in SNAP and Energy Assistance during the year of the service date. DHS would destroy data for patients who did not match. For patients that DHS identified as being enrolled in these programs, DHS would send letters to those patients using the current safe address (or current address, if there is no safe address) from the hospital.

Patients would reach out to the hospitals to request a refund based on the letters received from DHS or the Office of the Comptroller. Based on the letter, the hospital would determine if the patients were eligible for free care and provide a refund to those that overpaid.

An alternative approach would be for the Office of the Comptroller and DHS to share identifiable data sets with each hospital for their patients at or below 200 percent FPL or enrolled in SNAP or Energy Assistance. The hospital will then contact the patient to inform them that they may be due a refund. At the patient's request, the hospital would determine if the patient was eligible for free care and, if so, provide a refund. This alternative approach allows patients to be contacted using patient portals, which is not possible if the Office of the Comptroller and DHS contact the patients.

Potential Benefits

Like Option 2, this option reduces burden on patients and hospitals compared to Option 1 by using state data to identify individuals who may be eligible for refunds. This option reduces the number of entities involved in data use and data transfers (HSCRC and the HIE are not involved in the process option) which lessens (but does not eliminate) data privacy and security concerns while also minimizing burden for the HSCRC and the HIE. In addition, State Agencies would not need to share data with the hospitals (such as tax data), which helps to protect the state data, unless the alternative approach for contacting patients is used.

Potential Risks

This option raises privacy and data security concerns for hospitals, as their patient data will be shared with the Office of the Comptroller and the DHS. If the alternative option is used for

contacting patients, there are also concerns about sharing identifiable tax and social services program data with hospitals.

In addition, patient portals could not be used to contact patients unless the alternative approach to contact patients was used. As discussed above, patient portals are the preferred method for contacting patients.

Hospitals have also expressed concerns that they will not be able to validate the authenticity of the letters that patients present to them related to potential eligibility for hospital refunds, since the hospitals will not have direct access to the information from the Office of the Comptroller and DHS (unless the alternative approach to contacting patients is used).

Option 4: Start with HSCRC Data

Under Option 4, the process starts with HSCRC case mix data. The HSCRC data will be used to identify patients who had a date of service between 2017 and 2021. This data would be combined with data from the State-designated HIE, Office of the Comptroller, DHS, and hospitals to identify and contact patients who may be eligible for refunds.

First, the HSCRC would match data from the case mix (hospital discharge) data set to identify patients who received a service from a hospital between 2017 and 2021. Since HSCRC does not have identifying information in its dataset that would enable linking to data from DHS or the Office of the Comptroller, HSCRC would send a data set to the HIE that contains, for each patient, the EID, hospital name, and date of service. The HIE will match this data to the HIE's master patient index (an index of patients whose data has passed through the HIE) to add identifying information. The HIE will destroy data for patients who do not match with the patient index. For patients that do match to the index, the HIE will add, for each patient, name, address (from the HIE), and other specified data elements specified to enable data matching with the Office of the Comptroller.

The HIE will send the resulting identifiable data set of patients who received a hospital service in 2017 through 2021 to the Office of the Comptroller. The Office of the Comptroller would match the HSCRC/HIE data set with tax data and identify patients who were at or below 200 percent of the federal poverty level during the year of the service date. After this matching process, the Office of the Comptroller would:

- destroy data from the HSCRC/HIE data set for patients over that income level, as these patients likely do not qualify for free hospital care;
- share the HSCRC/HIE data set with DHS for patients that did not match to tax data; and
- send to each hospital an identifiable data set for patients the Comptroller identified as having incomes at or below 200 percent FPL and were provided services at that hospital.

DHS would match the HSCRC/HIE data received from the Office of the Comptroller with enrollees in SNAP and Energy Assistance during the year of the service date. DHS will destroy

data for patients who did not match with these programs. For patients that DHS identified as being enrolled in these programs, DHS would share with each hospital an identifiable data set for their patients that meet the eligibility criteria.

Hospitals would match the data provided by the Office of the Comptroller and DHS with their data and review their records to determine if the patient actually paid an out-of-pocket cost for the service. If the patient paid a bill, the hospital would identify the patient's current contact information (including safe address, if available) in their data. The hospital will then contact the patients who paid a bill to inform them that they may be due a refund. At the patient's request, the hospital would determine if the patient was eligible for free care and, if so, provide a refund. identify current safe addresses (or current addresses, if there is no safe address).

Table X: Comparison of Process Options

Statutorily Required Elements of the Process to Provide Refunds	Option 1: Hospital and Patient-provided Data Only	Option 2: Start with Comptroller Data	Option 3: Start with Hospital Data	Option 4: Start with HSCRC Data
Patient Identification (HG §19–214.4(a)(1))	*May meet this requirement (see question above).* Under this option, all patients who paid for a hospital service will be contacted. The hospital will determine the patient's eligibility for free care based on information available to the hospital and information provided by the patient (the same process that is used to determine financial assistance eligibility).	*Meets this requirement.* Under this option, Comptroller, HIE, HSCRC, DHS, and Hospital data will be used to identify patients who may be eligible for a refund.	*Meets this requirement.* Under this option, hospital, Comptroller, and DHS data will be used to identify patients who may be eligible for a refund.	*Meets this requirement.* Under this option, HSCRC, HIE, Comptroller, DHS, and hospital data will be used to identify patients who may be eligible for a refund.
Patient Reimbursement (HG §19–214.4(a)(2))	All options meet this requirement. Patients who qualify for reimbursement will receive refunds from the hospital.			
Safe Address (HG §19–214.4(a)(3))	*Meets this requirement.* The hospitals would contact patients using current safe addresses (or current addresses, if there is no safe address).	*Meets this requirement.* The hospitals would contact patients using current safe addresses (or current addresses, if there is no safe address).	*Meets this requirement.* State agencies would use current safe addresses (or current addresses, if there is no safe address) from hospitals to contact patients.	*Meets this requirement.* The hospitals would contact patients using current safe addresses (or current addresses, if there is no safe address).
Data Sharing & Data Protection (HG §19–214.4(a)(4))	*Lowest*: This option does not require data sharing, except between the hospital and the patient. This option minimizes concerns with data privacy	*High*: This option requires extensive data sharing between State Agencies and hospitals. This option presents significant risks for data privacy and	*Moderately High*: This option requires some data sharing between hospitals and State Agencies. This option presents risks for data privacy and security.	*High*: This option requires extensive data sharing between State Agencies and hospitals. This option presents significant risks for data privacy and

	and security, including compliance with Federal and State law.	security.		security.
Other Policy Issues	**Option 1: Hospital Data Only**	**Option 2: Start with Comptroller Data**	**Option 3: Start with Hospital Data**	**Option 4: Start with HSCRC Data**
Protecting Domestic Violence Survivors and other Special Populations	All options meet the safe address requirement. Additional concerns related to alternative outreach methods (including patient portals) and the content of any messages to patients is discussed elsewhere in this report and applies to all of the process options.			
Minimizing the burden on patients who may be eligible for refunds	*Highest*: This process requires the most work by patients	*Lower*: State Agency and hospital data is used to identify patients who are likely due a refund, such that patients will not need to provide evidence of income or social services program enrollment.		
Minimizing the burden and cost to hospitals.	*High*: This option results in the largest burden for hospitals as hospitals must evaluate information from patients to determine income and/or social services program enrollment.	*Lower*: Option 2, 3, and 4 reduce hospital burden by using State data to determine income or social services program enrollment. However, under Options 2 and 4 hospitals do the outreach to patients.	*Lowest*: Option 2, 3, and 4 reduce hospital burden by using State data to determine income or social services program enrollment. Under this option, unlike all other options, hospitals do not do the outreach to patients, reducing some administrative burden relative to options 2 and 4.	*Lower*: Option 2, 3, and 4 reduce hospital burden by using State data to determine income or social services program enrollment. However, under Options 2 and 4 hospitals do the outreach to patients.
Minimizing the burden to State Agencies	*Lowest*: No State Agency data is used in this option.	*Higher*: This option requires extensive data sharing between State agencies.	*Highest*: This option requires data sharing between State agencies and, unlike the other process options, requires State agencies to contact patients.	*Higher*: This option requires extensive data sharing between State agencies.

Potential Benefits

Like Options 2 and 3, this option reduces burden on patients and hospitals compared to Option 1 by using state data to identify individuals who may be eligible for refunds.

Potential Risks

This option raises significant concerns about the privacy and security of tax data, since identifiable patient information is shared with the Office of the Comptroller, DHS, and hospitals, and tax and social services program data is shared with hospitals.

Finally, this option has a high number of data transfers and thus presents a high risk for a data breach. This option puts a relatively high burden on State Agencies, compared with Option 1.

Additional Details of the Process

In addition to the statutorily required elements of the refund process and four process options for identifying eligible patients, additional details will be clarified in the final refund process. This section describes those additional refund process elements and clarifications, identifies which process options these process elements apply to, and includes legislative language for process elements that require legislative changes.

Hospital Services Only

Health General § 19-214.4 only applies to hospital services that are subject to regulation by HSCRC. HSCRC does not interpret this law to apply to physician services or other health services that are not regulated by HSCRC. This clarification applies to all process options described in this report.

Refund Amounts

Out-of-Pocket Amount

The refunds provided to patients under Health General § 19-214.4 are for amounts paid directly by the patient or guarantor (i.e., out-of-pocket payments), not for amounts covered by an insurer (whether paid directly to the hospital or to the patient). This clarification applies to all process options described in this report.

Minimum Amount

Under the law and regulations in effect from 2017 through 2021, hospitals were not required to provide refunds in amounts of $25 or less.[38] Requiring refunds of less than $25 would increase costs and administrative burdens on hospitals. In general, the refund process incorporates the relevant processes in the hospital financial assistance regulations that were in effect during this period and applying the $25 minimum would be consistent with this approach. However, it could be argued that Health General § 19-214.4 has no limit on a minimum refund amount, thereby superseding the pre- existing law and regulation with respect to the refund amount.

The following amendment to Health General §19-214.4 would clarify that the minimum refund amount in existing regulations applies to the process to provide refunds.

> After "(c)" insert **"Under this section, a hospital may, but is not required to, provide a refund for a total amount of $25 or less.**
> **(d)"**

Time of Care

Health General § 19-214.4 requires that the process identify "patients who paid for hospital services who may have qualified for free care …at the time of care". For purposes of the refund process, the phrase "time of care" means the date that the hospital service was provided, regardless of when the bill was sent or when the bill was paid. The process under Health General § 19-214.4 applies to hospital services that were provided to the patient from January 1, 2017, through December 31, 2021. This clarification applies to all process options described in this report.

The following amendment to Health General §19-214.4 would clarify that "time of care" means the hospital date of service.

> In subsection (a)(1), strike "time of care" and insert "**date the hospital service was provided**".

Eligibility Data

The following process elements clarify rules related to determining patient eligibility based on income or social services program enrollment.

Data from the Year of the Date of Service Only

If the process that is used to determine potential eligibility for free hospital care uses data from State Agencies (process Options 2 through 4), potential eligibility for financial assistance will be based on the tax data or social services enrollment data for the same year as the hospital date

[38] Health-General Article Section 19-214.2(c) requires a hospital to provide a refund "of amounts exceeding $25" collected from or on behalf of a patient who within 2 years after the date of service was found to be eligible for free care at the time of the service. COMAR 10.37.10.26A-2(3)(a) states the same.

of service. Tax data or program enrollment data from a year other than the year of the date of service will not be used.[39] This clarification is not relevant to process Option 1.

Income

The following process elements relate to determining potential eligibility for free care based on income.

Family Income

Eligibility for free care under the hospital financial assistance law[40] is based on family income, not individual income.

- For purposes of process Option 1, income eligibility for a refund shall use the same family-based income criteria that is in the hospital financial assistance law as it was in effect for 2017 through 2021.
- For process Options 2, 3, and 4, which use tax data to determine income eligibility, the patient's household income in the tax data (or individual income, if filing as an individual) shall be treated as the "family income" for purposes of the process of determining refunds.

De Facto Evidence of Income

For process Options 2, 3, and 4, if the tax data applicable for the year of the hospital service date demonstrates that the patient's household income was at or below 200 percent FPL for that year, the hospital shall treat the tax data from the Office of the Comptroller as de facto evidence of the patient's eligibility for free hospital care based on income. This process element is not relevant to process Option 1.

The following amendment to Health General §19-214.4 would clarify that hospitals can treat the information from the Office of the Comptroller as de facto evidence of income eligibility for hospital free care for purposes of refunds.

Redesignate subsections (b)-(d) as subsection (c) through (e).
After subsection (a) insert the following:
"(b) For purposes of the process under subsection (a), each hospital shall treat tax data from the Office of the Comptroller as de facto evidence of an individual's income."

Presumptive Eligibility

For process Options 2, 3, and 4, if data from DHS indicates that a patient was enrolled in a social service benefit program that qualified for presumptive eligibility for free care

[39] This is different from the process that was used in the 2021 report. In that report, if tax data was available for one year, and not the other year, then the tax data was used as the best estimate of the patient's income in the year for which the tax data was not available. This approach made sense for a future-focused, state-wide estimate of the potential impact of policies. On the individual level, incomes are highly variable and using data from a different year would result in a high rate of error.
[40] Health General §19-214.1

in the year of the date that the patient received hospital services, the hospital shall treat the data from DHS as de facto evidence of the patient's eligibility for free hospital care. This process element is not relevant to process Option 1.

The following amendment to Health General §19-214.4 would clarify that hospitals can treat the information from DHS as de facto evidence of income eligibility for hospital free care for purposes of refunds.

Redesignate subsections (b)-(d) as subsection (c) through (e).
After subsection (a) insert the following:
"(b) For purposes of the process under subsection (a), each hospital shall treat data from the Department of Human Services as de facto evidence of an individual's presumptive eligibility for free care."

Asset Tests

Under Maryland regulations, hospitals have the discretion to adopt asset tests as a component of their financial assistance policies. For purposes of the refunds under the refund law, a hospital that had an asset test in effect on the date that a patient received a hospital service may apply the asset test policy that the hospital had in effect on the date of service, or may apply their current asset test policy, whichever is more beneficial to the patient. This choice is at the discretion of the hospital but must be applied consistently by the hospital throughout the implementation of Health General §19-214.4. A hospital may only apply an asset test to determine a patient's eligibility for a refund for hospital care if the hospital had that asset test in effect in their financial assistance policy on the date of the hospital service related to that potential refund.[41] A hospital that did not have an asset test in effect on the date of service may not apply an asset test in determining patient eligibility for a refund. This process element applies to all process options.

Communications with Patients

Number of Contacts with Patients

For Options 1, 2, and 4, the final process will need to be clear on how often the hospital needs to contact patients. Stakeholders disagreed on the extent of these efforts. Some stakeholders felt that sending a single communication to the patient was sufficient[42] and aligned with the requirements of HB 694 (2022) as introduced. Other stakeholders felt that hospitals should be required to reach out to patients multiple times. Requiring additional outreach to patients would increase costs for hospitals. A potential policy on this topic could allow for different rules based on mode of contact (e.g., patient portals vs. mailed letters) and the disposition of a mailed letter.

[41] The same asset test language that is currently in COMAR 10.37.10.26A- 2(2)(c) was in these regulations in 2017. Thus, the asset test regulations apply for the whole period covered by Health General §19-214.4.
[42] Hospitals noted that patients receive notifications of the availability of financial assistance at discharge and with each bill.

For example, hospitals could be required to provide additional outreach to patients who did not respond to the first message, but no additional outreach would be necessary for letters which the hospital knows failed to reach the patient (for example, letters “returned to sender”). The Stakeholder Workgroup will discuss this topic in more detail once the final refund process is selected from the options. The final refund process must be clear on this issue, so that hospitals would know when they had completed their obligations under the law.

If Option 3 is the final process, the refund process would require the Office of the Comptroller and DHS to only send one letter to patients. This is aligned with the requirements of HB 694 (2022) as introduced.

Hospital Patient Support

HB 694, as introduced, required each hospital to create a website about the refund process.

The following amendment to Health General §19-214.4 would clarify that hospitals must create a webpage on the refund process.

> Redesignate subsection (c) as subsection (d).
> Insert after subsection (b) the following:
> **(c) Each hospital shall create a webpage that includes information about refunds and the process to apply for refunds under this section, including relevant timelines and a telephone number and email address for questions about the process.**

This process element applies to all process options.

State Agency Patient Support

A single State Agency should provide support to patients who have questions or complaints about the process to provide refunds under Health General §19-214.4, including information on a webpage and timely responses to patient emails and phone calls. For all process options, patients should be encouraged to first direct questions to the hospitals.

For all process options, the legislature could consider assigning this task to either HSCRC or the Health Education and Advocacy Unit (HEAU) in the Office of the Attorney General. Both agencies have responsibilities related to responding to patient billing questions and complaints. However, both agencies have limited staff resources. The potential volume of patient questions and complaints is unknown; thus, the level of staffing that will be required by these agencies to support this task is unknown.

HSCRC requests that the General Assembly clearly assign this task to either HSCRC or HEAU.

Reporting to HSCRC Required

Health General §19-214.4 requires HSCRC to report on the implementation of the refund process in January 2024. As noted in page 13, it would be helpful to add language to the statute to require all of the entities participating in the refund process to report data to the HSCRC in order for the HSCRC to complete the required report and conduct oversight of the process. Draft legislative language for this requirement is included on page 14.

Given that the legislation proposed in this report will likely not become effective until July 2023, HSCRC notes that only limited data on the refund process will likely be available in time for inclusion in the report required in January 2024. The legislature should consider changing this reporting deadline to October 2024 to allow for more complete reporting on the process.

The following amendment to Health General §19-214.4 would change the deadline for the next required report to the legislature, allowing for the inclusion of more data on the implementation of the refund process in that report.

> *In Health General §19-214.4(c)(1), strike "January 1, 2024" and insert "**October 30, 2024**".*

HSCRC Rates

HB 694 (2022), as introduced, contained the following language: "the Commission may not raise hospital rates, as part of the annual update factor, to offset the Hospital's direct refunds to patients under…" that bill. While this language did not become law, HSCRC intends to follow the bill's intent on this topic.

Reimbursement of State agencies

HB 694 (2022), as introduced, contained the following language: "Each hospital shall reimburse the Commission, the Office [of the Comptroller], and the Department of Human Services for the costs incurred in complying with" the refund law. If the legislature wants the hospitals to reimburse State agencies for the cost of implementing and monitoring the refund process, the legislature should consider adding similar language to the refund law. A reimbursement amount based on the hospital's proportion of the total number of patients who were identified by the State agencies as potentially eligible for refunds in a designated year would result in a fairly equitable distribution of this expense between hospitals.

The following amendment to Health General §19-214.4 would require hospitals to pay for administrative costs of the State Agencies.

> *In Health General §19-214.4, insert after subsection (d) the following new subsection:*
> **(e) (1) Each hospital shall reimburse the Commission, the Office of the Comptroller, and the Department of Human Services for the costs incurred in complying with this section.**
> **(2) Each hospital's share of the total cost will be determined based on the**

hospital's proportion of the total number of patients who were identified by the State agencies as potentially eligible for refunds in a designated year, as determined by the Commission.
(3) The Office of the Comptroller and the Department of Human Services shall, quarterly, provide information to the Commission on the costs incurred related to this section.
(4) HSCRC shall provide each hospital with the amount due, based on the costs incurred by the Office of the Comptroller, the Department of Human Services, and the Commission.

This language works for process Options 2 through 4. The HIE is not included in this language, as HSCRC expects to include the costs of the HIE in HSCRC's costs. This amendment would need to be modified for Option 1. HSCRC believes that the Commission's existing fund could be used to receive these payments. However, if the General Assembly believes that a new fund is required, that fund would need to be created.

Conclusion

The refund law requires hospitals to provide refunds to individuals who paid for hospital services received in any year between 2017 and 2021 and were eligible, at the time of service, for free care from the hospital under Maryland law relating to hospital financial assistance.[43]

Stakeholders discussed the potential refund process during the 2022 interim. The Stakeholder Workgroup identified challenges in determining a final refund process related to the following policy goals:

- Minimizing the burden on patients by using data from State agencies and hospitals (and, in some scenarios, the State-designated HIE) to identify likely patient eligibility for refunds;
- Protecting the privacy of taxpayers, patients, and beneficiaries of social service benefit programs and minimizing the potential for misuse of data and/or a data breach;
- Protecting the privacy of special populations who are particularly sensitive to the exposure of health data, including people experiencing domestic violence;
- Minimizing the burden and cost to hospitals of implementing the requirement to identify patients and provide refunds; and
- Minimizing burden on State agencies to identify patients and monitor the refund process.

Stakeholders were not able to reach consensus on a potential process to provide refunds. Statutory changes are required to ensure that all entities involved in the final process are compliant with federal and state privacy and data security laws and to clarify roles and responsibilities for hospitals, the HIE, and State Agencies. These statutory changes will not resolve all of the challenges with developing and implementing a refund process.

[43] Health General §19-214.1

Appendix: Data and Methodology used in 2020 Report on Policy Proposals

In 2020, HSCRC submitted a report ("the 2020 report") to the legislature analyzing the potential impact of proposed future changes to hospital financial assistance law on uncompensated care (UCC).[44] Health General §19-214.4's requirement for hospitals to provide refunds was inspired by the findings of the 2020 report.[45] To complete the modeling required by this report, HSCRC used data for 2017 and 2018 from the following sources:

- Commission's hospital case mix data (de-identified hospital discharge data);
- State tax data from the Maryland Office of the Comptroller;
- Data from the Maryland Medical Care Database (MCDB), maintained by the Maryland Health Care Commission, which contains enrollment and claims data from private insurers operating in Maryland; and
- the State-Designated Health Information Exchange's (HIE's) master patient index, which was used to match data between the Office of the Comptroller and HSCRC.

The data matching and data sharing process was designed to limit the use of personally identifiable tax and patient information, balancing the goal of enabling analysis to complete the required report with taxpayer and patient privacy.

The goal of the 2020 report was designed to provide an estimate of the cost of proposed changes to hospital free care rules on a State-wide basis. HSCRC's modeling for the 2020 report relied on HSCRC's ability to determine the percent of the patients who likely paid for hospital visits in a year that they were eligible for free hospital care (i.e., under 200% FPL). HSCRC used deidentified tax data from 2017 and 2018 to verify federal poverty levels ranges for some patients using income range (tax) data from the Office of the Comptroller. For patients that did not have matching data from the Office of the Comptroller, HSCRC made a number of assumptions related to patient income to complete the modeling. In those cases, HSCRC only has an estimate of the percentage of patients in a certain category of patients who may be eligible for a refund, with no ability to determine which individual patients in that category might be eligible. HSCRC did not use data from any other State agencies, aside from the Office of the Comptroller, for the analysis in the 2020 report. Thus, HSCRC could not determine if patients without known incomes were enrolled in programs that qualify for presumptive eligibility for hospital financial assistance.

HSCRC's analysis for the 2020 report was not designed to provide individual refunds to patients and was conducted on de-identified data. For all data used for the 2020 report, HSCRC does not have patient names or contact information, which would be necessary to provide refunds to patients.

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[44] This report was required by Chapter 470 §2 (2020).

[45] For the 2020 report, as a component of the analysis used to estimate the potential impact of the proposed financial assistance policies on UCC, HSCRC modeled hospitals' performance in providing free hospital care using data from 2017 and 2018. HSCRC found that approximately 1% of total hospital charges to individuals who likely qualified for free care (or approximately $60 million statewide each year) were paid by those individuals. HSCRC does not have any evidence that this amount represents intentional or negligent actions by hospitals.

Patients with Known Incomes

Of the patient visits in 2017 and 2018 that HSCRC modeled as possibly qualifying for free care and having paid a bill for the 2020 report, approximately 45 percent of the patients had known incomes based on tax data from the same year as the patient visit. The Office of the Comptroller provided HSCRC with deidentified income data for the analysis for the 2020 report.[46] Approximately 13 percent of patient visits had income data from either 2017 or 2018, but not both years. For the 2020 report, HSCRC staff assumed that a patient's income data from one year applied to both years. This assumption is not appropriate for purposes of providing patient refunds for the five year period covered by Health General §19-214.4, as income in one year may not be an accurate reflection of the patient's income in the other years. The patient's income may have changed, such that the patient was not eligible for free care if the patient visit was in a year without income data. For example, if income data is only available for one year, it is unlikely it will be accurate for all five years in the 2017-2021 time period.

Patients with Imputed Incomes

Forty-three (43) percent of the patient visits that HSCRC modeled as possibly being eligible for free care and having paid a bill for the 2020 report did not have matching income data from the Office of the Comptroller for either 2017 or 2018. For these patients, HSCRC made assumptions about a patient's likely income for purposes of generating reasonable State-wide cost estimates. This approach made sense for the purposes of population-level modeling of future policies required under Chapter 470 (2020). On the individual level, HSCRC staff do not know which patients in this population actually had incomes under 200 percent FPL based on the data used in the 2020 report.

Most of these patients were Medicare beneficiaries. Nationally, 20 percent of Medicare beneficiaries have incomes below 200 percent FPL.[47] For the analysis for the 2020 report, staff randomly assigned an income of under 200 percent FPL to 20 percent of the Medicare beneficiaries with no income data from the Office of the Comptroller.[48] This process was sufficient to provide an estimate of future costs but is not accurate for the purpose of providing refunds.

[46] The tax data was matched with data from HSCRC to identify patients with a hospital visit in a year who possibly paid a bill.

[47] "Distribution of Medicare Beneficiaries by Federal Poverty Level," Kaiser Family Foundation, https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-by-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[48] This application of the national 20 percent figure to Medicare beneficiaries in Maryland who did not file income taxes may result in an over or under estimate of the income level of Medicare beneficiaries without income data in Maryland. HSCRC does not have national data on the percent of Medicare beneficiaries who file taxes and how the incomes of tax filers may differ from non-filers. It is possible that non-filers have a different income distribution than individuals who filed taxes.