maryland
health services
cost review commission

Final Guidelines for Hospital Payment Plans, per Chapter 770 of 2021

May 11, 2022

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Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
Md. Code Health General §19-214 requires that hospitals provide financial assistance to low-income patients and follow rules around medical debt collection that are designed to protect patients. In 2021, the legislature changed the medical debt requirements, including a requirement that HSCRC develop guidelines for hospitals that require that payment plans be income based (Chapter 770, 2021).	The hospital payment plan guidelines meet the requirements of the statute. These guidelines were developed with input from a stakeholder workgroup.	Hospitals must follow these guidelines for any patient payment plans. These guidelines will likely cause some payment plans to have longer durations, which may negatively impact the amount collected. In addition, hospitals may need to update their online payment portals to meet the requirements of these guidelines. Those IT changes should be a one-time expense.	These guidelines provide additional protections for consumers, including by limiting the amount due under payment plans to five percent of the patient's income and prohibiting the collection of interest for patients who are eligible for financial assistance, in addition to providing other protections for patients.	To the extent that income-based payment plans are most beneficial to lower-income patients, this policy will help improve equity for this group, which includes a disproportionate share of racial and ethnic minorities.

Commission Action

Staff are presenting the Final "Guidelines for Hospital Payment Plans", in order to meet the requirements of Health General §19-214.2, as amended by Chapter 770 of 2021, Maryland Code. The final guidelines are in Appendix I. A description of the changes made to the Guidelines between April and May, including responses to comments received in the April 6 - April 20 public comment period is in Appendix II. These guidelines will be incorporated by reference into COMAR 10.37.10.26, which will also be presented in this meeting.

Introduction

Since 2009, Maryland law has required each hospital to have a policy on the collection of debts owed by patients (Health General §19-214.2, Maryland Code). This law contains protections for patients (including

the prohibition of interest on certain debt owed by self-pay patients, a prohibition on hospitals selling debt, and a requirement that the hospital's policy clearly describe the hospital's procedures for collecting a debt).[1] Chapter 770 of 2021 made a number of statutory changes to Health General §19-214.2, Maryland Code, related to hospital collection of medical debt, including adding a requirement that hospital payment plans for patients must meet guidelines developed by the Commission.

Chapter 770 required that the HSCRC seek input from stakeholders in drafting these guidelines. Accordingly, the HSCRC formed a Workgroup on Hospital Payment Plan Guidelines, which met three times between January and February of 2022 to review guidelines originally drafted by HSCRC staff, in collaboration with staff from the Office of the Commissioner of Financial Regulation (OCFR). [2] Workgroup members and members of the public were also invited to submit written comments on the draft guidelines. In April, staff presented draft guidelines to the Commission and solicited public comments. HSCRC and OCFR staff revised the draft guidelines presented based on the comments received in April and the discussion in the April Commission meeting.

HSCRC staff are working on additional documents to provide further guidance for hospitals on implementation of Chapter 770, including a Frequently Asked Questions document, which is being developed in conjunction with OCFR. In addition, HSCRC staff plan to update the Special Audit Procedures to reflect the new requirements in Chapter 770.

Background

Chapter 770 of 2021

In addition to updating hospital debt collection requirements under Health General §19-214, Chapter 770 of 2021 required HSCRC to develop guidelines for hospital income-based payment plans with input from stakeholders. Chapter 770 requires that these guidelines include:

(1) the amount of medical debt owed to the hospital;

(2) the duration of the payment plan based on a patient's annual gross income;

(3) guidelines for requiring appropriate documentation of income level;

(4) guidelines for the payment amount, that:

[1] Maryland law also requires that hospital provide financial assistance to lower income patients (Health General §19-214.1, Maryland Code).

[2] OCFR is Maryland's consumer financial protection agency and financial services regulator. Among other things, the Office is responsible for licensing and supervising state-licensed financial institutions including consumer debt collection agencies, consumer lenders, installment lenders, credit services businesses, debt management companies to ensure compliance with the laws and regulations of Maryland.

(i) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income; and

(ii) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article;

(5) guidelines for:

(i) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days after the due date of the first payment; and

(ii) a prohibition on interest payments for patients who qualify for free or reduced–cost care;

(6) guidelines for modification of a repayment plan that does not create a greater financial burden on the patient; and

(7) a prohibition on penalties or fees for prepayment or early payment.

Chapter 770 required that, in drafting the income-based payment plan guidelines, HSCRC seek input from stakeholders, including the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt.

Hospitals must demonstrate that they attempted in good faith to meet the requirements of the guidelines before either filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector for a debt owed on a hospital bill by a patient.[3]

The effective date for Chapter 770 was January 1, 2022. On December 7, 2021, Kathryn Rowe, the Assistant Attorney General for the General Assembly, issued an opinion that the provision of Chapter 770 relating to the guidelines "could be given partial effect until such time as the guidelines are in place. All other provisions in the bill can be given full effect on the January 1, 2022, effective date".[4] Ms. Rowe further stated, "some of the provisions that have to be included in the hospitals' income-based payment plans are clearly stated in the law itself, even before the Commission has issued its final guidelines", so that hospitals could comply with those provisions until the Commission guidelines were in place.

[3] Health General §19–214.2 (e)(5), Maryland Code
[4] Kathyn M. Rowe, Letter to the Honorable Lorig Charkoudian regarding Chapter 770 of 2021, December 7, 2021.

Policy Goals

In developing these guidelines, HSCRC staff balanced a number of different policy goals. In general, HSCRC sought to focus on the requirements of Health General §19-214.2, as amended by Chapter 770 (2021). This contained the potential scope of the guidelines.

Under the law, income-based payment plans are now required for all patients, regardless of income. In developing these guidelines, HSCRC staff sought to balance providing protections to the low- and moderate-income patients who will most benefit from these protections, while trying to minimize the burden on other patients.

HSCRC staff also worked to ensure that the guidelines provide patients with all the protections required by law while continuing to require that hospitals seek payment from patients who can pay their bills. This balance is intended to avoid unnecessary increases in uncompensated care costs.

Process for Soliciting Stakeholder Input

To meet the requirements in Chapter 770 of 2021 for developing the payment plan guidelines, HSCRC formed a Workgroup on Hospital Payment Plan Guidelines. This group reviewed a draft of the guidelines written by HSCRC staff in conjunction with staff from the Office of the Commissioner of Financial Regulation (OCFR). The workgroup met three times:

1. 6:30 – 8:30pm on Monday, January 24, 2022
2. 9:00 – 11:00am on Friday, February 11, 2022
3. 3:00 – 5:00pm on Monday, February 28, 2022

HSCRC publicized this workgroup on its website[5] and also sent workgroup notifications to a group of interested stakeholders. Each workgroup meeting included time for public comment from non-workgroup members. In addition to receiving input through workgroup discussion, HSCRC also asked workgroup members and other interested stakeholders to provide written comments. HSCRC staff considered both the verbal comments from workgroup discussion and the written comments received from stakeholders when writing the draft of the guidelines presented to the Commission in April. See Appendix III for the full list of workgroup members.

Staff presented the draft guidelines in the April Commission meeting and solicited public comments. Staff informed the workgroup members and members of the public who had attended workgroup meetings of the public comment period. HSCRC and OCFR staff revised the guidelines based on comments received in April and the discussion in the April Commission meeting.

[5] See https://hscrc.maryland.gov/Pages/Workgroup-on-Hospital-Payment-Plan-Guidelines.aspx

Additional Documents

In addition to these guidelines presented in this recommendation, HSCRC staff are presenting updates to regulations to align COMAR 10.27.10.26 with the changes that Chapter 770, 2021, made to Health General §§ 19–214.1 and 19–214.2 in the May meeting. This update to COMAR incorporates the payment plan guidelines by reference.

HSCRC staff are also working with staff from OCFR on a “Frequently Asked Questions” document to provide additional clarity on Chapter 770 for hospitals and debt collectors.

Finally, HSCRC plans to update its Special Audit Procedures to ensure hospitals are complying with Chapter 770.

Appendix I: Final Guidelines

1) **Definitions:**
   a) In these guidelines, the following terms have the meanings indicated.
   b) Terms defined.
      i) **Financial Hardship:** "Financial hardship" has the same meaning as in COMAR 10.37.10.26.
      ii) **Written:** "Written" has the same meaning as in COMAR 10.37.10.26.
2) **Scope:**
   a) **In general:** These guidelines apply to any payment plans offered by hospitals to patients to pay for medically necessary hospital services after the services are provided.
   b) **Prepayment plans**: These guidelines do not apply to arrangements to make payments prior to the provision of a hospital service. Nothing in these guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that–
      i) A hospital may not require or steer a patient to enter into such an arrangement solely to avoid the application of these guidelines; and
      ii) Such an arrangement terminates once the hospital service is rendered.
   c) **Unregulated services:** These guidelines apply only to hospital services that are regulated by the HSCRC. These guidelines do not apply to services that are not regulated by the HSCRC, including physician services.
   d) **Limitation of guidelines:** These guidelines do not prevent hospitals from extending payment plans for services or at times that are outside the parameters of these guidelines. Except as otherwise required by law or regulation, payment plans that are outside the parameters of these guidelines are not subject to these guidelines.
3) **Access to payment plans:**
   a) **Available to all Maryland residents:** Maryland hospitals must make payment plans available to all patients who are Maryland residents, including people temporarily residing in Maryland due to work or school, irrespective of their:
      i) Insurance status;
      ii) Citizenship status;
      iii) Immigration status; or
      iv) Eligibility for reduced cost care, including reduced cost care due to financial hardship, under COMAR 10.37.10.26.
   b) **Treatment of non-residents:** These guidelines do not prevent hospitals from extending payment plans to patients who are not described in subsection (a). Except as otherwise required by law or

regulation, payment plans for patients who are not described in subsection (a) are not subject to these guidelines.

4) **Notice requirements:**
   a) **Notice of availability of payment plans***:*
      i) **Posted notice:** A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of the availability of a payment plan and whom to contact at the hospital for additional information.
      ii) **Information sheet:** A written notice of availability of payment plans is contained in the information sheet required under COMAR 10.37.10.26.
      iii) **Before prepayment plan:** A hospital shall provide a written notice of the availability of payment plans to a patient before a patient enters into a prepayment plan described in guideline 2 for a medically necessary hospital service.
   b) **Notice of terms before execution:** Hospitals shall provide written notice of the terms of a payment plan to a patient before the patient agrees to enter the payment plan. The terms of the payment plan must include:
      i) The amount of medical debt owed to the hospital;
      ii) The interest rate applied to the payment plan and the total amount of interest expected to be paid by the patient under the payment plan;
      iii) The amount of each periodic payment expected from the patient under the payment plan;
      iv) The number of periodic payments expected from the patient under the payment plan.
      v) The expected due dates for each payment from the patient;
      vi) The expected date by which the account will be paid off in full;
      vii) The treatment of any missed payments (including missed payments under guideline 10) and default;
      viii) There are no penalties for early payments; and
      ix) If the hospital plans to apply a periodic recalculation of monthly payment amounts under guideline 10, the process for such recalculation.
   c) **Notice of plan after execution:** A hospital shall promptly provide a written payment plan, including items listed in subsection (b), to the patient following execution by all parties. The payment plan shall be provided to the patient at least 20 days before the due date of the patient's first payment under the payment plan.
5) **Payment plans are income-based:**
   a) **Financial assistance:** Before entering a payment plan with a patient, a hospital shall evaluate if the patient is eligible for financial assistance (including free care, reduced-cost care, and reduced-cost care due to financial hardship) in accordance with COMAR 10.37.10.26. The hospital will apply the financial assistance reduction prior to entering into a payment plan with a patient.

b) **Monthly payment amounts are limited to 5% of income:** Under a payment plan subject to these guidelines, a hospital shall not require a patient to make total payments in a month that exceed 5% of the lessor of the individual patient's federal or State adjusted gross monthly income. This applies to total amounts due under the plan, including both principal and interest.

c) **Calculation of income:** A hospital shall calculate a patient's income by taking the following steps:
   i) **Determining the income amount:** Determining the lessor of the patient's federal or state adjusted gross income. If the patient has not provided their tax returns, the hospital shall use available information, including information provided by the patient, to approximate the patient's adjusted gross income. Income that is not taxable, such as certain gifts, should not be treated as income for purposes of determining the income limitation under this guideline.
   ii) **Determining the number of filers and dependents:** The hospital shall determine the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of tax filers and dependents.
   iii) **Determining the patient's pro-rata share of income:** The hospital shall divide the income amount determined under paragraph (i) by the number of tax filers and dependents under paragraph (ii). This is the individual patient's income for purposes of determining the 5% limit on the income-based payment plans under these guidelines.

d) **Income documentation:**
   i) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s.
   ii) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation. Such an attestation must include the patient's income and the number of filers and dependents on their tax return.

e) **Expenses:** A hospital shall consider information provided by a patient about household expenses in determining the amount of the monthly payment due under a payment plan.

f) **Application to multiple payment plans:**
   i) **Hospitals:** A hospital must ensure that the total monthly payment amount for all payment plans provided to a patient by such hospital, when added up collectively, may not exceed the income limitation under subsection (b).
   ii) **Hospital system:** A hospital system must ensure that the total monthly payment amount for all payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, may not exceed the income limitation under subsection (b).

6) **Duration of payment plan:** The duration of a payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5% of the patients income as calculated under guideline (5).
7) **Interest and fees:**
    a) **No interest for patients eligible for charity care:** A hospital shall not charge and collect interest on the medical debt amount owed under a payment plan for patients who qualify for free or reduced-cost care, including reduced cost care due to financial hardship, under COMAR 10.37.10.26.
    b) **No Interest for self-pay patients:** A hospital may not charge interest on bills incurred by self-pay patients in a payment plan.
    c) **Interest allowed:** A hospital may charge interest under a payment plan for a patient who is not described in subsection (a) or (b). A hospital is not required to charge interest for a payment plan.
    d) **Interest rate.** A payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization.
    e) **Timing:** Interest may not begin before 180 days after the due date of the first payment.
    f) **Late payments:** A hospital may not charge additional fees or interest for late payments.
8) **Early payment:**
    a) **Prepayment allowed:** Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under a payment plan. Any prepayment made under this provision is not subject to guideline (5)(b).
    b) **No fees or penalties:** A hospital shall not assess fees or otherwise penalize early payment of a payment plan provided by a patient.
    c) **Solicitation of early payments prohibited:** Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in a payment plan.
9) **Limited Modifications of Payment Plans:**
    a) **Limitations on payment plan modifications:** A hospital may only modify a payment plan in the following ways:
        i) **Limitation on payment amount:** A hospital shall not modify a payment plan in a way that requires a patient to make a monthly payment that exceeds the percent of the patient's income used to set the monthly payment amount under the initial payment plan as provided for in guideline (5).
        ii) **No increase in interest rate:** A hospital may not increase the interest rate on a payment plan when making a modification under this guideline.

iii) **Change in duration:** The duration of a modified payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitations under guideline (5) and section (d) of this guideline.

b) **Process for modifying a payment plan:**

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

ii) **Reconsideration for financial assistance:** If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance (including free care, reduced-cost care, and reduced-cost care due to financial hardship under COMAR 10.37.10.26). The hospital will apply the financial assistance reduction in its modification of the payment plan.

iii) **Change in income:** If a patient notifies a hospital that the patient's income has changed, as calculated under guideline (5), then the hospital shall offer to modify the payment plan to meet the requirement of subsection (a)(i) of this guideline.

iv) **Expenses:** A hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

v) **Mutual agreement:** A hospital shall not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.

vi) **Notice of terms:** The hospital must provide the patient with a written notice of all payment plan terms, consistent with the requirements of guideline (4), upon modifying a payment plan under this guideline.

10) **Hospital-initiated changes to payment plans based on changes to patient income:**

a) **Recalculation allowed:** A hospital may, in the terms of an initial payment plan that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as subject to and calculated under guideline (5).

b) **Notice included in initial payment plan:** The hospital may only recalculate payment amounts under this guideline if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the payment plan, per guideline 4(b)(ix). The patient's agreement to enter into the payment plan after receiving that notice constitutes consent to the payment recalculations allowed under this subsection.

c) **Limitations on modification apply:** Guideline 9(a) and paragraphs (i), (ii), (iii), (iv), and (vi) of Guideline 9(b) apply to payment recalculations under this subsection.

d) **Frequency of recalculation:** A hospital may not seek a recalculation of the monthly payment amount, as provided for under this subsection more often than once every 3 years.

e) **Treatment of missing information:** If a patient does not provide income information on the request of the hospital seeking to make a change to a payment plan under this subsection and the patient is in good standing on the patient's payments under the payment plan the hospital shall not change the monthly payment amounts under the payment plan.

11) **Treatment of missed payments:**

a) **First Missed Payment:**

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

ii) The hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

iii) The hospital may consider a patient to be in default on the payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under paragraph (i).

b) **Additional missed payments:**

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

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

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

iv) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this subsection as additional payments at the end of the payment plan, thereby extending the length of the payment plan.

v) The hospital shall provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the payment plan.

12) **Treatment of loans and extension of credit:** After a hospital service is provided to the patient, a hospital, hospital affiliate, or a third-party in partnership with a hospital may not make any loan or extension of credit to the patient that is inconsistent with these guidelines for medical debt resulting from that service.

13) **Application of Credit Provisions of Maryland Commercial Code:** A payment plan is an extension of credit subject to Maryland credit regulations under the Annotated Code of Maryland, Commercial Law Article, Title 12. Accordingly, hospitals must elect or otherwise enter into an income-based payment

plan under one of the subtitles thereunder. Pursuant to CL § 11-302(b)(6), if a hospital is making an extension of credit through a payment plan for hospital services rendered under Subtitles 1, 9, or 10 of the Commercial Law Article, and is otherwise not making loans or acting as a loan broker, then an Installment License issued by the Commissioner of Financial Regulation may not be required to engage in such activity.

14) **Books and Records:** A hospital must retain books and records on payment plans for at least 3 years after the payment plan is closed.
15) **Default:** If a patient defaults on a payment plan and the parties are not able to agree to a modification, then the hospital must follow the provisions of its collection and write-off policy for the collection of debt established in accordance with COMAR 10.37.10.26, before a hospital may write this debt off as bad debt.

Appendix II: Staff Description of Changes to the Guidelines, including Responses to Public Comments Received through the April Public Comment Period

This appendix contains a description of the changes made to the Guidelines presented in the April Commission meeting, including HSCRC staff responses to comments received in the April 6 - April 20 public comment period. These HSCRC staff responses are in addition to the discussion in the "Staff Explanation for Guidelines for Hospital Payment Plans" included in the April Meeting materials.

Guideline 1: Definitions: A commenter urged the HSCRC to change the definition of "written" under Guideline 1(b) to include that communication must be delivered both in paper form and electronically. Another commenter expressed support for allowing notification through either paper or electronic means. HSCRC believes that either electronic or written notice is sufficient. The language specifically allows patients to opt-out of electronic notices if they would prefer paper, giving patients choice over the document format. After review, HSCRC has decided to move this definition into the proposed regulations and cross reference it in these guidelines.

Guideline 2: Scope: The draft guideline 2 in April focused on distinguishing between payment plans that occur after a debt is incurred, rather than before a service is provided.

A commenter urged the Commission to reconsider applying the Guidelines to prepayment plans or include a requirement that hospitals give patients notice at the time an appointment is made that payment plans would be available to patients making prepayments after services are provided. Another commenter noted that it is not feasible to apply these guidelines to prepayment arrangements because it may be impossible to determine whether patients owe any outstanding balance until they receive the service and their insurance claim is adjudicated. As HSCRC noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, HSCRC does not believe that the statute directed HSCRC to apply the guidelines to prepayment plans. In addition, not all of these guidelines would be appropriate for prepayment plans. HSCRC has added a requirement to guideline 4 that hospitals must provide notice to patients of the availability of payment plans before entering into a pre-payment plan.

Another commenter suggested striking all language about pre-payment arrangements due to the concern that these arrangements are entirely outside of the scope of these guidelines. HSCRC mentions prepayment plans in this guideline to clarify that these guidelines do not apply to pre-payment plans. HSCRC believes this clarity is important for hospitals and debt collectors who must operationalize this bill.

Another commenter suggested that HSCRC clarify that these payment plan guidelines are limited to hospital bills and not physician expenses. HSCRC has added language to guideline 2 that clarifies that these guidelines only apply to HSCRC regulated hospital services.

HSCRC added language to make clear that hospitals can provide payment plans for situations that are out-of-scope of these guidelines and those payment plans are not subject to these guidelines.

Guideline 3: Access to payment plans: No changes were made to this guideline.

Guideline 4: Notice requirements

Guideline 4(a): Notice of availability of payment plans: In April, this guideline only contained language about hospitals posting notices in the hospital about the availability of payment plans. One commenter suggested that, in addition to conspicuous notices, hospitals should also provide "paper" notice before discharge from the hospital. As is outlined in HSCRC's proposed updates to COMAR 10.37.10.26, this information will be included in the information sheet, which is provided before discharge. HSCRC added language to the guidelines to clarify that notice of payment plans is included in the information sheet. In addition, HSCRC added a provision to require notice of the existence of payment plans before a hospital and patient enter into a prepayment plan that is out-of-scope of these guidelines.

Guideline 4(b): Notice of terms before execution: One commenter suggested removing this subsection over concern that it would be administratively burdensome for hospitals and delay the start of payment plans. HSCRC continues to agree with feedback received from other commenters that this requirement is necessary to ensure consumers know the terms of the payment plan before they agree to enter into the payment plan.

Another commenter proposed adding the interest rate and the total amount of interest due under the payment plan to the notice requirements under 4(b). HSCRC has added that language to the guideline.

In the April meeting, a Commissioner asked how patients would be made aware of the option to make early payments under a prepayment plan. Staff have added language to this notice requirement to require notice that there is no penalty for early payments.

The commenter also recommended adding a requirement that hospitals outline the good faith requirement from Chapter 770 into the notice so that patients have know that they can make complaints based on lack of good faith requirements when applicable. More specifically, they proposed adding to the list under 4(b) "The requirement that a hospital shall demonstrate that it attempted in good faith to meet the requirements of the medical debt statute and the Commission's Guidelines before filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector." HSCRC and OCFR focused on providing the terms of the prepayment plan in this notice. The good faith requirement is not a term of the payment plan. HSCRC does not think that this guideline is the appropriate place to address this topic. HSCRC

understands the concerns that advocates have about how the "good faith" language in Chapter 770 will be applied. HSCRC has included some language related to this topic in the proposed regulations.

Guideline 4(c): Notice of plan after execution: One commenter expressed concern that requiring hospitals to provide the payment plan to the patient at least 10 days before the due date of the patient's first payment may not give patients sufficient time if a hospital sends the payment plan by mail. For this reason, HSCRC is proposing to update Guideline 4(c) to provide for a 20 day period.

Guideline 5: Payment plans are income-based:

Guideline 5(a): Financial assistance: A commenter requested an edit to guideline 5a to clarify that any reduction in the amount due based on financial assistance should be applied prior to entering into the payment plan. HSCRC agreed that the new second sentence in this guideline adds clarity and accepted this change.

Guideline 5(b): Monthly payment amounts are limited to 5% of income: HSCRC staff have not changed this guideline.

Several commenters encouraged the Commission to allow patients to pay more than 5% if the patient chose to do so. Some commenters urged the Commission to alter the draft guidelines to allow patients to self-select the plan that best suits their financial needs if hospitals disclose that payment plans cannot by law exceed 5% of adjusted gross monthly income, without requiring hospitals to determine if the monthly payment about does exceed 5% of the patient's monthly income. One commenter asserted that the Commission could read the requirement in Health General § 19-214.2 that the installment payment amount may not exceed 5% of gross monthly income, along with the statutory prohibition of penalties or fees for prepayment or early payment to allow this approach. Some of these commenters are concerned about the length of payment plans that may arise due to the 5% income restriction. Commission staff do not agree that this approach would meet either the letter or the intent of the law. Staff believe that a monthly billing statement that contains an "amount due" that the hospital knows is greater than 5% of the adjusted gross monthly income amounts to a solicitation of a payment amount in excess of 5% of monthly income, which is prohibited by the law. HSCRC considers any amount in excess of 5% of monthly income (with the exception of a missed payment under guideline 10(a)) to be an early payment. Guideline 8 specifically prohibits the solicitation of early payments. A hospital cannot avoid this obligation by purposely failing to ask for the patient's income (such as by using a checkbox to have the patient certify that the monthly payment amount does not exceed 5% of their income -see additional discussion of this topic under guideline 5(d)).

At least one commenter asked HSCRC to clarify that hospitals may not solicit payments above 5% of monthly income. As stated above, HSCRC considers any amount in excess of 5% of monthly income (with the exception of a missed payment under guideline 10(a)) to be an early payment and guideline 8 specifically prohibits the solicitation of early payments.

Guideline 5(c): Calculation of income: HSCRC staff have not changed this guideline.

One commenter noted that the use of individual income for payment plans in Health General § 19-214.2 does not align with the use of family income for the determination of eligibility for hospital financial assistance in Health General § 19-214.1 and asked HSCRC to use family income in the payment plan guidelines. HSCRC agrees that these statutory differences lead to inconsistencies in how the payment plan policies and financial assistance policies will be applied and increase administrative challenges for hospitals and patients, who will have to make two different income determinations, one for financial assistance and one for payment plans. As noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April:

> "The meaning of "individual patient" was discussed in the workgroup and in a number of written comments. Staff had …concerns about the use of individual income to determine the income limitation for hospital payment plans…. [T]he use of individual income could result in unintended outcomes. For example, a non-working spouse or child in a high income household could have an individual income of zero dollars, resulting in an income repayment plan with monthly payments that cannot exceed $0, despite that household's ability to pay for hospital charges. Conversely, a sole wage owner in a family with many dependents would end up with a higher payment plan income limit if their dependents were not taken into account. Several approaches were suggested to staff to address this issue. Ultimately, staff decided that using a pro-rata share of the adjusted gross income for all filers and dependents was the best approach."

Commenters stated their belief that using the "pro-rata" approach, rather than "family income", would be complex and confusing for both hospitals and consumers. Staff continue to believe that the pro-rata approach is the appropriate approach given the constraints of the statutory language. A statutory change to use the term "family income" in Health General § 19-214.2 would allow for greater consistency between the financial assistance and payment plan policies and reduce administrative burden for patients and hospitals.

Guideline 5(d): Income documentation: One commenter requested that HSCRC allow patients to self-attest that the payment plan they select will result in monthly payments that are no more than 5% of GMI. The commenter felt that this approach would make entering a payment plan easier for patients by minimizing the amount of information that the patient needs to provide the hospital.

HSCRC staff discussed the request to use the attestation described in this comment in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April.

> "Some stakeholders requested that the guidelines allow hospitals to request patient attestations that the payment plan is under 5% of income (for example, through a check box and signature) rather than collecting income information from the patient. HSCRC staff do not think this approach satisfies the legal requirement that payment plans be income-based. Hospitals may not accept such an attestation in lieu of collecting information about the patient's income and calculating the 5% limitation on the monthly payment amount based on the income information provided by the patient."

A commenter asserted that the process in this guideline would push "hospitals to require more verification as the number of dependents directly affects the monthly amount the hospital can collect from the patient." Guideline 5(d) allows hospitals to accept attestation of patient income. HSCRC has edited this guideline to clarify that the attestation can also include the number of filers and dependents. Staff do not think that hospitals would require more verification given that patient attestation of this information is allowed. As noted in Guideline 5(d), an attestation of the patients income and the number of filers and dependents is sufficient documentation of income.

Guideline 5(e) Expenses: HSCRC staff have not changed this guideline.

Some commenters requested striking this language due to concerns that it is burdensome for hospitals. Other commenters requested that each hospital develop and report to the HSCRC on a process for documenting how they incorporate expenses into the payment plan. As noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, we included this guideline in response to commenters noting that various expenses other than medical debt may affect a patient's ability to pay for hospital services. Medical debt is addressed through reduced cost care with financial hardship under the statutory requirements for financial assistance. Staff continue to believe that this guideline, which encourages but does not require hospitals to consider expenses, appropriately balances different viewpoints on this issue.

At least one commenter asked that we include a definition of "household expenses". Given that the consideration of these expenses is not required, HSCRC does not feel that including a definition is necessary.

Guideline 5(f): Limitation of payment amount across hospitals. HSCRC staff have not changed this guideline.

Several commentators (and a Commissioner) asked HSCRC to consider a guideline that limited all payment plans across all hospital systems to the 5% monthly income limit. In the "Staff Explanation

for Guidelines for Hospital Payment Plans" in April, "HSCRC staff determined that operationalizing such an approach was not operationally feasible at this time." Staff continue to believe that the operational complexity of this topic would prevent effective implementation. In addition, HSCRC does not read the language of the law to require this coordination.

Guideline 6: Duration of payment plan: HSCRC staff have not changed this guideline.

Guideline 7: Interest and Fees: HSCRC staff have not changed this guideline.

One commenter stated that the interest rate should not be capped at 6%, but rather tied to market indicators. This commenter noted that this would recognize the additional carrying costs of the longer payment plans that will result from these guidelines. As noted in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, 6% is the constitutional rate of interest in Maryland, which is the default interest rate in Maryland law when no interest rate is provided in statute.[6] This interest rate is half of the interest rate cap that HSCRC applies to hospital accounts receivable under COMAR 10.37.10.26 (B)(3). Additional discussion of the selection of this interest rate is in the "Staff Explanation for Guidelines for Hospital Payment Plans" from April. Staff continue to believe this is an appropriate interest rate.

Guideline 8: Early payment: HSCRC staff have not changed this guideline.

In the April meeting, a Commissioner asked how patients would be made aware of the option to make early payments. HSCRC staff made a change to guideline 4 to include notice that there is no prepayment penalties in the information that the patient receives before entering into a payment plan under these guidelines.

Guideline 9: Limited Modifications of Payment Plans

The heading of this guideline was changed to reflect the narrower scope of the guideline (see the discussion of the new guideline 10 below for more information).

Guideline 9(a): Limitations on payment plan modifications: HSCRC staff have not changed this guideline.

Guideline 9(b): Process for modifying a payment plan: Commenters asked that HSCRC change Guideline 9(b)(i) so that hospitals may not refer the outstanding balance owed to a collection agency or for legal action until 180 days after providing a written response to the patient's request for a modification of the payment plan. As stated in the April "Staff Explanation for Guidelines for Hospital Payment Plans", staff "decided that 30 days was appropriate given the many other protections against referral for collections or legal action in Health General §19-214.2."

[6] Article 3, §57 of the Maryland Constitution states that "the legal rate of interest shall be six per cent per annum; unless otherwise provided by the General Assembly ".

In guideline 9(b)(ii), HSCRC added a sentence to clarify that any reduction in the amount due based on financial assistance should be applied prior to entering into the payment plan. This is similar to a change made in guideline 5(a).

Another commenter requested the HSCRC change Guideline 9(b)(iii) to allow hospitals to modify a payment plan if a patient's income has changed, not just when the income decreased. HSCRC staff made this change in the guideline.

Guideline 10 (former Guideline 9(c)): Hospital-initiated changes to payment plans based on changes to patient income: HSCRC staff moved this provision from a subsection in guideline 9 to it's own guideline, to make clear that the process contemplated in this guideline is different than the modifications discussed in guideline 9.

A commenter requested that HSCRC amend this guideline so that the recalculation period is not limited to once every 3 years. Instead, the commenter recommended that HSCRC allow for hospital discretion to identify when recalculation may be appropriate. As stated in the April "Staff Explanation for Guidelines for Hospital Payment Plans", HSCRC staff believe it is important for hospitals to have the option to change monthly payment amounts under payment plans based on changes in patient income. This is particularly important given that staff expect that payment plans will be longer under this new regulatory regime than they have been in the past. However, this must be balanced with protections for consumers so that they are not subject to constant attempts by hospitals to recalculate payment plan amounts. Staff believe 3 years is the right balance.

Another commenter suggested removing this guideline, with the belief that the guideline allowing patients to modify their payment plan suffices. HSCRC staff continue to believe that this guideline, which gives hospitals the option to recalculate payment amounts but does require hospitals to do so, is important given the significant change that is expected in the length of payment plans under these guidelines.

Another commenter suggested that Guideline 10(b) could be clarified. Staff added language to this guideline in response to this comment.

Guideline 11 (former guideline 10): Treatment of Missed Payments: HSCRC staff have not changed this guideline.

Guideline 12 (former guideline 11) : Treatment of Loans and Extension of Credit: HSCRC has simplified the language in the guideline based on feedback from commentators.

One commenter urged HSCRC to strike this language due to the belief that this creates unnecessary confusion regarding third-party financing options that are available to patients. HSCRC continues to believe that this language is necessary to ensure that hospitals comply with these guidelines regardless of the type of arrangement (payment plan, loan, other extension of credit) that exists between the hospital and the

patient. This guideline only applies to loans and extensions of credit offered by the hospital or by a third party in partnership with the hospital. In the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, staff noted that-

> "HSCRC does not intend these guidelines to apply to loans or other forms of consumer credit (such as credit cards) that are offered to patients by entities that do not have an agreement with the hospital. These forms of credit are outside of the scope of Health General §19-214.2 and are subject to Federal and State law related to consumer protection for financial products."

HSCRC believes that striking this language would not succeed in clarifying this issue, but would instead create an opportunity for use of loans and extensions of credit that violate these guidelines.

Former Guideline 12: Debt Collectors: Commenters suggested that HSCRC provide further detail in this guideline. On further consideration of this feedback and the law, HSCRC has moved the text of this guideline to the proposed regulations.

In addition, commenters urged HSCRC to clarify the auditing and compliance process to enforce these guidelines and to clarify the consumer complaint process. HSCRC does not think the guidelines are the appropriate document to use to address these concerns. HSCRC plans to update audit procedures to reflect the requirements of Chapter 770.

Guideline (13): Application of Credit Provisions of Maryland Commercial Code: HSCRC staff have not changed this guideline.

Guideline (14): Books and Records: Commenters requested that this guideline be changed to make the minimum document retention 3 years after the payment plan is closed or "*for the period of time required to retain medical records under federal or state laws, whichever is later."*

As stated in the "Staff Explanation for Guidelines for Hospital Payment Plans" in April, this guideline was drafted to allow sufficient time for the purposes of HSCRC's audit requirements and for compliance activities. This guideline does not supersede any other record retention requirements under law. The HSCRC does not feel it is necessary to mention other federal and state laws in this provision, but rather simply state the time period that is necessary for compliance with these guidelines.

Guideline 15: Default: HSCRC staff have not changed this guideline.

A commenter encouraged the HSCRC to update its audit procedures to ensure these guidelines are followed. HSCRC plans to update the special audit procedures, which is a separate document, to add auditing requirements related to Chapter 770, 2021. The HSCRC does not believe that these guidelines are the best place to address this concern.

Uncompensated Care and Bad Debt. One commenter "strongly encourage[d] the Commission to balance the proposed payment plan guidelines to safeguard reasonable rates for all payers, including out-of-pocket costs for all patients." HSCRC staff is not clear what specific changes the commenter is requesting to the guidelines, if any. HSCRC staff have worked throughout this process to meet the letter of the law and ensure consumer protections, while remaining mindful of the operational impacts of these guidelines on both hospitals and consumers.

HSCRC staff agree that the move to income-based guidelines will likely lengthen individual payment plans and this may have an impact on bad debt and uncompensated care HSCRC acknowledges that other commenters think these guidelines will reduce bad debt by increasing adoption of payment plans. HSCRC does not have data on current payment plan use or the rate of collections from those payment plans. HSCRC does not have a current reporting process to collect this data. As a result, it will be difficult, if not impossible, to isolate the impact of this change in policy on UCC and administrative costs. HSCRC will, as always, consider uncompensated care in setting future hospital rates.

Appendix III: Workgroup Members

1. Brett McCone, *Maryland Hospital Association*
2. Lakmini Kidder, *Johns Hopkins Health System*
3. Mark Norby, *University of Maryland Medical System*
4. Sue Whitecotton, *Medstar Health*
5. Cheryl Nottingham, *Atlantic General Hospital*
6. Bradley Boban, *Maryland Insurance Administration*
7. Pat O'Connor, *Health Education and Advocacy Unit of the Maryland Attorney General's Office*
8. Girume Ashenafi, *1199 SEIU United Healthcare Workers East*
9. Marceline White, *Maryland Consumer Rights Coalition*
10. Anna Palmisano, *Marylanders for Patient Rights*
11. Amy Hennen, *Maryland Volunteer Lawyers Service*
12. Tori Nefflen, *Patient Representative*
13. Godlee Davis, *DECO Recovery Management*
14. Leslie Bender, *Clark Hill Law Firm*
15. Neal Karkhanis, *League of Life and Health*
16. Kenneth Krach, *Office of the Commissioner of Financial Regulation*
17. Jedd Bellman, *Office of the Commissioner of Financial Regulation*
18. Megan Renfrew, *HSCRC*
19. Dennis Phelps, *HSCRC*
20. Stan Lustman, *HSCRC*

Appendix IV: Chapter 770, 2021

See Next Page

Chapter 770

(House Bill 565)

AN ACT concerning

Health Facilities – Hospitals – Medical Debt Protection

FOR the purpose of specifying the method for calculating family income to be used for certain purposes under a certain hospital financial assistance policy; requiring that the description of a hospital's financial assistance policy that is included on a certain information sheet include a certain section; requiring a hospital to submit annually a certain report to the Health Services Cost Review Commission at a certain time; requiring the Health Services Cost Review Commission to post certain information on its website; altering the required contents of a hospital's policy on the collection of debts owed by patients; ~~requiring a hospital to provide a refund of certain amounts collected from a patient or the guarantor of a patient who was found eligible for reduced–cost care on the date of service; establishing certain prohibitions on hospitals that charge interest fees on hospital bills;~~ prohibiting a hospital from charging interest or fees on certain debts incurred by certain patients; requiring a hospital to provide in writing to certain patients information about the availability of a certain installment payment plan; requiring a hospital to provide certain information to a patient, the patient's family, an authorized representative, or the patient's legal guardian at certain times; ~~prohibiting a certain payment plan from requiring a patient to make certain monthly payments and imposing certain penalties; requiring a hospital to determine certain adjusted monthly income in a certain manner under certain circumstances; requiring a certain payment plan to have a certain repayment period;~~ requiring the Health Services Cost Review Commission to develop certain guidelines, with input from stakeholders, for an income–based payment plan; prohibiting a hospital from seeking legal action against a patient on a debt owed until the hospital has implemented a certain payment plan; establishing that certain patients are deemed to be compliant with a certain payment plan under certain circumstances; requiring a patient to contact the health care facility and identify a certain plan under certain circumstances; authorizing a health care facility to waive certain payments required in a payment plan under certain circumstances; providing that a health care facility may not be required to waive certain payments; requiring a hospital to demonstrate that it attempted in good faith to meet certain requirements and guidelines before the hospital takes certain actions; providing that certain provisions of this Act do not prohibit a hospital from using a certain vendor for a certain purpose; altering and specifying certain time periods during which and the circumstances under which a hospital is prohibited from taking a certain action; prohibiting a hospital from reporting certain information about certain patients to a consumer reporting agency; prohibiting a hospital from taking certain actions against certain patients under certain circumstances; requiring a hospital to provide certain instructions to a consumer reporting agency under certain circumstances; repealing a certain authorization for a hospital to hold a certain lien; prohibiting a hospital from requesting a certain lien

in a certain action; prohibiting a hospital from filing an action or giving a certain notice to a patient for nonpayment of debt until after a certain time period; prohibiting a hospital from taking certain actions if the hospital files a certain action; prohibiting a hospital from requesting a certain writ to garnish certain wages or filing a certain action under certain circumstances; ~~prohibiting a hospital from filing a certain action if a certain debt is below a certain amount;~~ prohibiting a hospital from making a certain claim against an estate of a deceased patient under certain circumstances; authorizing a hospital to offer the family of a certain patient the ability to apply for financial assistance; prohibiting a hospital from filing a certain action ~~against a certain patient or~~ until certain conditions are met; ~~prohibiting a hospital from delegating certain collection activity to a debt collector to collect a certain amount of debt;~~ prohibiting certain individuals from being held liable for a certain debt; authorizing a certain individual to consent to assume a certain liability under certain circumstances; requiring a hospital to send a certain written notice of intent at least a certain period of time before filing a certain action; providing for the manner of delivery, content, and structure of a certain notice of intent; requiring a certain complaint to include a certain affidavit and be accompanied by certain documents; requiring that a hospital require a debt collector to have certain responsibility for meeting certain requirements under certain circumstances; requiring the Health Services Cost Review Commission, on or before a certain date, to compile certain information and prepare a certain ~~annual~~ report; requiring that a certain report be made available to the public in a certain manner and submitted to certain committees of the General Assembly; altering certain references by changing "outside collection agency" to "debt collector"; making conforming changes; requiring the Health Services Cost Review Commission, on or before a certain date and with input from certain stakeholders, to develop certain guidelines; requiring the Health Services Cost Review Commission, on or before a certain date, to report to certain committees of the General Assembly on certain guidelines; requiring the Health Services Cost Review Commission to conduct a certain study on uncompensated care; requiring the Maryland Health Care Commission to examine the feasibility of using the State–designated Health Information Exchange for a certain purpose and to make a certain report to certain committees of the General Assembly on or before a certain date; providing for a delayed effective date; and generally relating to hospital debt collection policies.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–214.1(b)(1)
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214.1(b)(2)(i) and (ii) and (f)(1)(i) and 19–214.2
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–214.1.

(b) (1) The Commission shall require each acute care hospital and each chronic care hospital in the State under the jurisdiction of the Commission to develop a financial assistance policy for providing free and reduced–cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill.

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

(i) Free medically necessary care to patients with family income at or below 200% of the federal poverty level**, CALCULATED AT THE TIME OF SERVICE OR UPDATED, AS APPROPRIATE, TO ACCOUNT FOR ANY CHANGE IN FINANCIAL CIRCUMSTANCES OF THE PATIENT THAT OCCURS WITHIN 240 DAYS AFTER THE INITIAL HOSPITAL BILL IS PROVIDED**;

(ii) Reduced–cost medically necessary care to low–income patients with family income above 200% of the federal poverty level, **CALCULATED AT THE TIME OF SERVICE OR UPDATED, AS APPROPRIATE, TO ACCOUNT FOR ANY CHANGE IN FINANCIAL CIRCUMSTANCES OF THE PATIENT THAT OCCURS WITHIN 240 DAYS AFTER THE INITIAL HOSPITAL BILL IS PROVIDED,** in accordance with the mission and service area of the hospital;

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

(i) Describes the hospital's financial assistance policy **AND INCLUDES A SECTION THAT ALLOWS FOR A PATIENT TO INITIAL THAT THE PATIENT HAS BEEN MADE AWARE OF THE FINANCIAL ASSISTANCE POLICY**;

19–214.2.

(a) **(1)** Each hospital **ANNUALLY** shall submit to the Commission**[**, at**]:**

(I) AT times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients**; AND**

(II) A REPORT INCLUDING:

1. THE TOTAL NUMBER OF PATIENTS BY RACE OR ETHNICITY, GENDER, AND ZIP CODE OF RESIDENCE AGAINST WHOM THE HOSPITAL,

OR A DEBT COLLECTOR USED BY THE HOSPITAL, FILED AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL;

2. THE TOTAL NUMBER OF PATIENTS BY RACE OR ETHNICITY, GENDER, AND ZIP CODE OF RESIDENCE WITH RESPECT TO WHOM THE HOSPITAL HAS AND HAS NOT REPORTED OR CLASSIFIED A BAD DEBT; AND

3. THE TOTAL DOLLAR AMOUNT OF THE ~~COSTS OF~~ CHARGES FOR HOSPITAL SERVICES PROVIDED TO PATIENTS BUT NOT COLLECTED BY THE HOSPITAL FOR PATIENTS COVERED BY INSURANCE, INCLUDING THE OUT–OF–POCKET COSTS FOR PATIENTS COVERED BY INSURANCE, AND PATIENTS WITHOUT INSURANCE.

(2) THE COMMISSION SHALL POST THE INFORMATION SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION ON ITS WEBSITE.

(b) The policy **SUBMITTED UNDER SUBSECTION (A)(1) OF THIS SECTION** shall:

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

(2) Prohibit the hospital from selling any debt;

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

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

(5) PROHIBIT THE HOSPITAL FROM REPORTING TO A CONSUMER REPORTING AGENCY OR FILING A CIVIL ACTION TO COLLECT A DEBT WITHIN 180 DAYS AFTER THE INITIAL BILL IS PROVIDED;

[(5)**] (6)** Describe the hospital's procedures for collecting a debt;

[(6)**] (7)** Describe the circumstances in which the hospital will seek a judgment against a patient;

[(7)**] (8)** In accordance with subsection (c) of this section, provide for a refund of amounts collected from a patient or the guarantor of a patient who was ~~[~~later~~]~~ found to be eligible for free ~~OR REDUCED–COST~~ care **[**on the date of service**]** ~~MORE THAN 240 DAYS AFTER THE FIRST POSTDISCHARGE~~ **WITHIN 240 DAYS AFTER THE INITIAL BILL WAS PROVIDED**;

[(8)**]** **(9)** If the hospital has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who ~~[~~later~~]~~ was found to be eligible for free ~~OR REDUCED–COST~~ care **[**on the date of the service**]** ~~MORE THAN 180 DAYS AFTER THE FIRST POSTDISCHARGE~~ **WITHIN 240 DAYS AFTER THE INITIAL BILL WAS PROVIDED** for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacate the judgment or strike the adverse information; **[**and**]**

[(9)**]** **(10)** Provide a mechanism for a patient to:

(i) Request the hospital to reconsider the denial of free or reduced–cost care; **[**and**]**

(ii) File with the hospital a complaint against the hospital or **[**an outside collection agency**]** **A DEBT COLLECTOR** used by the hospital regarding the handling of the patient's bill**; AND**

(III) ALLOW THE PATIENT AND THE HOSPITAL TO MUTUALLY AGREE TO MODIFY THE TERMS OF A PAYMENT PLAN OFFERED UNDER SUBSECTION (E) OF THIS SECTION OR ENTERED INTO WITH THE PATIENT; AND

(11) PROHIBIT THE HOSPITAL FROM COLLECTING ADDITIONAL FEES IN AN AMOUNT THAT EXCEEDS THE ~~COST OF THE HOSPITAL SERVICE~~ APPROVED CHARGE FOR THE HOSPITAL SERVICE AS ESTABLISHED BY THE COMMISSION FOR WHICH THE MEDICAL DEBT IS OWED ON A BILL FOR A PATIENT WHO IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

(c) (1) Beginning October 1, 2010, a hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2–year period after the date of service, was found to be eligible for free ~~OR REDUCED–COST~~ care on the date of service.

(2) A hospital may reduce the 2–year period under paragraph (1) of this subsection to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free ~~OR REDUCED–COST~~ care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the requested information.

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

(D) ~~**IF A HOSPITAL CHARGES INTEREST FEES ON A HOSPITAL BILL, THE HOSPITAL MAY NOT:**~~

~~**(1) CHARGE INTEREST IN EXCESS OF AN EFFECTIVE RATE OF SIMPLE INTEREST OF 1.5% PER ANNUM ON THE UNPAID PORTION OF A HOSPITAL BILL;**~~

~~**(2) CHARGE**~~ **A HOSPITAL MAY NOT CHARGE INTEREST OR FEES ON ANY DEBT INCURRED ON OR AFTER THE DATE OF SERVICE BY A PATIENT WHO IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE**~~**; OR**~~

~~**(3) BEGIN ACCRUAL OF INTEREST OR LATE PAYMENT CHARGES UNTIL 180 DAYS AFTER THE DATE OF THE LATER OF:**~~

~~**(I) THE END OF EACH REGULAR BILLING PERIOD; OR**~~

~~**(II) THE PATIENT'S DISCHARGE**~~**.**

(E) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A HOSPITAL SHALL PROVIDE IN WRITING TO EACH PATIENT WHO INCURS MEDICAL DEBT INFORMATION ABOUT THE AVAILABILITY OF AN INSTALLMENT PAYMENT PLAN FOR THE DEBT.

(2) A HOSPITAL SHALL PROVIDE THE INFORMATION UNDER PARAGRAPH (1) OF THIS SUBSECTION TO THE PATIENT, THE PATIENT'S FAMILY, THE PATIENT'S AUTHORIZED REPRESENTATIVE, OR THE PATIENT'S LEGAL GUARDIAN:

(I) BEFORE THE PATIENT IS DISCHARGED;

(II) WITH THE HOSPITAL BILL;

(III) ON REQUEST; AND

(IV) IN EACH WRITTEN COMMUNICATION TO THE PATIENT REGARDING COLLECTION OF HOSPITAL DEBT.

~~**(3) (I) A PAYMENT PLAN OFFERED UNDER THIS SUBSECTION MAY NOT:**~~

~~**1. REQUIRE THE PATIENT TO MAKE MONTHLY PAYMENTS THAT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; OR**~~

~~2. IMPOSE PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.~~

~~(II) IF THE PATIENT DOES NOT SUBMIT TAX DOCUMENTATION TO BE USED FOR DETERMINING A PAYMENT PLAN, A HOSPITAL SHALL DETERMINE A PATIENT'S ADJUSTED GROSS MONTHLY INCOME BY FOLLOWING STANDARDS FOR THE DETERMINATION OF INCOME THAT ARE DEVELOPED BY THE COMMISSION IN REGULATIONS.~~

~~(4) A PAYMENT PLAN UNDER THIS SUBSECTION SHALL HAVE A REPAYMENT PERIOD THAT IS NOT LESS THAN THE LONGER OF:~~

~~(I) 36 MONTHS; OR~~

~~(II) A TIME PERIOD THAT WOULD ENSURE THAT PAYMENTS ARE GREATER THAN ACCRUED INTEREST.~~

(3) (I) THE COMMISSION SHALL DEVELOP GUIDELINES, WITH INPUT FROM STAKEHOLDERS, FOR AN INCOME–BASED PAYMENT PLAN OFFERED UNDER THIS SUBSECTION THAT INCLUDES:

1. THE AMOUNT OF MEDICAL DEBT OWED TO THE HOSPITAL;

2. THE DURATION OF THE PAYMENT PLAN BASED ON A PATIENT'S ANNUAL GROSS INCOME;

3. GUIDELINES FOR REQUIRING APPROPRIATE DOCUMENTATION OF INCOME LEVEL;

4. GUIDELINES FOR THE PAYMENT AMOUNT THAT:

A. MAY NOT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; AND

B. SHALL CONSIDER FINANCIAL HARDSHIP, AS DEFINED IN § 19–214.1(A) OF THIS SUBTITLE;

5. GUIDELINES FOR:

A. THE DETERMINATION OF POSSIBLE INTEREST PAYMENTS FOR PATIENTS WHO DO NOT QUALIFY FOR FREE OR REDUCED–COST CARE, WHICH MAY NOT BEGIN BEFORE 180 DAYS AFTER THE DUE DATE OF THE FIRST PAYMENT; AND

B. A PROHIBITION ON INTEREST PAYMENTS FOR PATIENTS WHO QUALIFY FOR FREE OR REDUCED–COST CARE;

6. GUIDELINES FOR MODIFICATION OF A PAYMENT PLAN THAT DOES NOT CREATE A GREATER FINANCIAL BURDEN ON THE PATIENT; AND

7. A PROHIBITION ON PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.

(II) A HOSPITAL MAY NOT SEEK LEGAL ACTION AGAINST A PATIENT ON A DEBT OWED UNTIL THE HOSPITAL HAS ESTABLISHED AND IMPLEMENTED A PAYMENT PLAN POLICY THAT COMPLIES WITH THE GUIDELINES DEVELOPED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.

~~(5)~~ (4) (I) A PATIENT SHALL BE DEEMED TO BE COMPLIANT WITH A PAYMENT PLAN IF THE PATIENT MAKES AT LEAST 11 SCHEDULED MONTHLY PAYMENTS WITHIN A 12–MONTH PERIOD.

(II) IF A PATIENT MISSES A SCHEDULED MONTHLY PAYMENT, THE PATIENT SHALL CONTACT THE HEALTH CARE FACILITY AND IDENTIFY A PLAN TO MAKE UP THE MISSED PAYMENT WITHIN 1 YEAR AFTER THE DATE OF THE MISSED PAYMENT.

(III) THE HEALTH CARE FACILITY MAY, BUT MAY NOT BE REQUIRED TO, WAIVE ANY ADDITIONAL MISSED PAYMENTS THAT OCCUR WITHIN A 12–MONTH PERIOD AND ALLOW THE PATIENT TO CONTINUE TO PARTICIPATE IN THE INCOME–BASED PAYMENT PLAN AND NOT REFER THE OUTSTANDING BALANCE OWED TO A COLLECTION AGENCY OR FOR LEGAL ACTION.

~~(6)~~ (5) (I) A HOSPITAL SHALL DEMONSTRATE THAT IT ATTEMPTED IN GOOD FAITH TO MEET THE REQUIREMENTS OF THIS SUBSECTION AND THE GUIDELINES DEVELOPED BY THE COMMISSION UNDER PARAGRAPH (3) OF THIS SUBSECTION BEFORE THE HOSPITAL:

~~(I)~~ 1. FILES AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT; OR

~~(II)~~ 2. DELEGATES COLLECTION ACTIVITY TO A DEBT COLLECTOR FOR A DEBT OWED ON A HOSPITAL BILL BY A PATIENT.

(II) SUBPARAGRAPH (I) OF THIS PARAGRAPH DOES NOT PROHIBIT A HOSPITAL FROM USING AN ELIGIBILITY VENDOR TO PROVIDE OUTREACH TO A PATIENT FOR PURPOSES OF ASSISTING THE PATIENT IN QUALIFYING FOR FINANCIAL ASSISTANCE.

[(d)**] (F)** (1) For at least **[**120**] 180** days after ~~[~~issuing an initial patient bill~~]~~ ~~THE FIRST POSTDISCHARGE BILL WAS PROVIDED~~, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment **[**unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill**]**.

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

(3) A HOSPITAL MAY NOT REPORT ADVERSE INFORMATION TO A CONSUMER REPORTING AGENCY REGARDING A PATIENT WHO AT THE TIME OF SERVICE WAS UNINSURED OR ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

(4) A HOSPITAL MAY NOT REPORT ADVERSE INFORMATION ABOUT A PATIENT TO A CONSUMER REPORTING AGENCY, COMMENCE A CIVIL ACTION AGAINST A PATIENT FOR NONPAYMENT, OR DELEGATE COLLECTION ACTIVITY TO A DEBT COLLECTOR:

(I) IF THE HOSPITAL WAS ~~INFORMED~~ NOTIFIED IN ACCORDANCE WITH FEDERAL LAW BY THE PATIENT OR THE INSURANCE CARRIER THAT AN APPEAL OR A REVIEW OF A HEALTH INSURANCE DECISION IS PENDING~~, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE~~ WITHIN THE IMMEDIATELY PRECEDING 60 DAYS; OR

(II) ~~UNTIL 60 DAYS AFTER~~ IF THE HOSPITAL HAS COMPLETED A REQUESTED RECONSIDERATION OF THE DENIAL OF FREE OR REDUCED–COST CARE THAT WAS APPROPRIATELY COMPLETED BY THE PATIENT WITHIN THE IMMEDIATELY PRECEDING 60 DAYS.

(5) IF A HOSPITAL HAS REPORTED ADVERSE INFORMATION ABOUT A PATIENT TO A CONSUMER REPORTING AGENCY, THE HOSPITAL SHALL INSTRUCT THE CONSUMER REPORTING AGENCY TO DELETE THE ADVERSE INFORMATION ABOUT THE PATIENT:

(I) IF THE HOSPITAL WAS INFORMED BY THE PATIENT OR THE INSURANCE CARRIER THAT AN APPEAL OR A REVIEW OF A HEALTH INSURANCE DECISION IS PENDING, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE; OR

(II) UNTIL 60 DAYS AFTER THE HOSPITAL HAS COMPLETED A REQUESTED RECONSIDERATION OF THE DENIAL OF FREE OR REDUCED–COST CARE.

[(e)**] (G)** (1) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill.

(2) **[**If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt**] A HOSPITAL MAY NOT REQUEST A LIEN AGAINST A PATIENT'S PRIMARY RESIDENCE IN AN ACTION TO COLLECT DEBT OWED ON A HOSPITAL BILL**.

(3) (I) A HOSPITAL MAY NOT FILE AN ACTION AGAINST A PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL OR GIVE NOTICE TO A PATIENT UNDER SUBSECTION (I) OF THIS SECTION UNTIL AFTER 180 DAYS AFTER THE ~~FIRST POSTDISCHARGE~~ INITIAL BILL WAS PROVIDED.

(II) IF A HOSPITAL FILES AN ACTION TO COLLECT THE DEBT OWED ON A HOSPITAL BILL, THE HOSPITAL MAY NOT REQUEST THE ISSUANCE OF OR OTHERWISE KNOWINGLY TAKE ACTION THAT WOULD CAUSE A COURT TO ISSUE:

1. A BODY ATTACHMENT AGAINST A PATIENT; OR

2. AN ARREST WARRANT AGAINST A PATIENT.

(4) A HOSPITAL MAY NOT REQUEST A WRIT OF GARNISHMENT OF WAGES OR FILE AN ACTION THAT WOULD RESULT IN AN ATTACHMENT OF WAGES AGAINST A PATIENT TO COLLECT DEBT OWED ON A HOSPITAL BILL IF THE PATIENT IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

~~**(5) A HOSPITAL MAY NOT FILE AN ACTION AGAINST A PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL IN AN AMOUNT OF $1,000 OR LESS.**~~

~~**(6)**~~ **(5) (I) A HOSPITAL MAY NOT MAKE A CLAIM AGAINST THE ESTATE OF A DECEASED PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL IF THE DECEASED PATIENT WAS KNOWN BY THE HOSPITAL TO BE ELIGIBLE FOR FREE CARE UNDER § 19–214.1 OF THIS SUBTITLE OR IF THE VALUE OF THE ESTATE AFTER TAX OBLIGATIONS ARE FULFILLED IS LESS THAN HALF OF THE DEBT OWED.**

(II) A HOSPITAL MAY OFFER THE FAMILY OF THE DECEASED PATIENT THE ABILITY TO APPLY FOR FINANCIAL ASSISTANCE.

~~(7)~~ (6) A HOSPITAL MAY NOT FILE AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT:

~~(I) WHO WAS UNINSURED AT THE TIME SERVICE WAS PROVIDED; OR~~

~~(II)~~ ~~UNTIL~~ UNTIL THE HOSPITAL DETERMINES WHETHER THE PATIENT IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

~~(8) A HOSPITAL MAY NOT DELEGATE COLLECTION ACTIVITY TO A DEBT COLLECTOR FOR DEBT OWED ON A HOSPITAL BILL BY A PATIENT THAT IS $1,000 OR LESS.~~

(H) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A SPOUSE OR ANOTHER INDIVIDUAL MAY NOT BE HELD LIABLE FOR THE DEBT OWED ON A HOSPITAL BILL OF AN INDIVIDUAL WHO IS AT LEAST 18 YEARS OLD.

(2) AN INDIVIDUAL MAY VOLUNTARILY CONSENT TO ASSUME LIABILITY FOR THE DEBT OWED ON A HOSPITAL BILL OF ANY OTHER INDIVIDUAL IF THE CONSENT IS:

(I) MADE ON A SEPARATE DOCUMENT SIGNED BY THE INDIVIDUAL;

(II) NOT SOLICITED IN AN EMERGENCY ROOM OR DURING AN EMERGENCY SITUATION; AND

(III) NOT REQUIRED AS A CONDITION OF PROVIDING ANY EMERGENCY OR NONEMERGENCY HEALTH CARE SERVICES.

(I) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AT LEAST 45 DAYS BEFORE FILING AN ACTION AGAINST A PATIENT TO COLLECT ON THE DEBT OWED ON A HOSPITAL BILL, A HOSPITAL SHALL SEND WRITTEN NOTICE OF THE INTENT TO FILE AN ACTION TO THE PATIENT.

(2) THE NOTICE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) BE SENT TO THE PATIENT BY CERTIFIED MAIL AND FIRST–CLASS MAIL;

(II) BE IN SIMPLIFIED LANGUAGE ~~AS DETERMINED IN REGULATIONS ADOPTED BY THE COMMISSION~~ AND IN AT LEAST 10 POINT TYPE;

(III) INCLUDE:

1. THE NAME AND TELEPHONE NUMBER OF:

A. THE HOSPITAL;

B. IF APPLICABLE, THE DEBT COLLECTOR; AND

C. AN AGENT OF THE HOSPITAL AUTHORIZED TO MODIFY THE TERMS OF THE PAYMENT PLAN, IF ANY;

2. THE AMOUNT REQUIRED TO CURE THE NONPAYMENT OF DEBT, INCLUDING PAST DUE PAYMENTS, PENALTIES, AND FEES;

3. A STATEMENT RECOMMENDING THAT THE PATIENT SEEK DEBT COUNSELING SERVICES;

4. TELEPHONE NUMBERS AND INTERNET ADDRESSES OF ~~NONPROFIT AND GOVERNMENT RESOURCES, INCLUDING~~ THE HEALTH EDUCATION ADVOCACY UNIT IN THE OFFICE OF THE ATTORNEY GENERAL, AVAILABLE TO ASSIST PATIENTS EXPERIENCING MEDICAL DEBT;

5. AN EXPLANATION OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY; AND

~~6. AN EXPLANATION OF THE STATE MEDICAL DEBT COLLECTION PROCESS AND TIMELINE;~~

~~7. AN EXPLANATION OF THE PATIENT'S RIGHT TO APPEAL TO THE PATIENT'S INSURANCE CARRIER, THE MARYLAND INSURANCE ADMINISTRATION, OR THE HOSPITAL FOR ANY DENIED REIMBURSEMENT OR ACCESS TO FREE OR REDUCED-COST CARE, AND THE NEED TO INFORM THE HOSPITAL IF AN APPEAL IS IN PROCESS; AND~~

~~8.~~ 6. ANY OTHER RELEVANT INFORMATION PRESCRIBED BY THE COMMISSION; AND

(IV) BE PROVIDED IN THE PATIENT'S PREFERRED LANGUAGE OR, IF NO PREFERRED LANGUAGE IS SPECIFIED, EACH LANGUAGE SPOKEN BY A LIMITED ENGLISH PROFICIENT POPULATION THAT CONSTITUTES 5% OF THE

POPULATION WITHIN THE JURISDICTION IN WHICH THE HOSPITAL IS LOCATED AS MEASURED BY THE MOST RECENT FEDERAL CENSUS.

(3) THE NOTICE REQUIRED UNDER THIS SUBSECTION SHALL BE ACCOMPANIED BY:

(I) AN APPLICATION FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, ALONG WITH INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE, AND THE TELEPHONE NUMBER TO CALL TO CONFIRM RECEIPT OF THE APPLICATION;

(II) THE AVAILABILITY OF A PAYMENT PLAN TO SATISFY THE MEDICAL DEBT THAT IS THE SUBJECT OF THE HOSPITAL DEBT COLLECTION ACTION; AND

(III) THE INFORMATION SHEET REQUIRED UNDER § 19–214.1(F) OF THIS SUBTITLE.

(J) A COMPLAINT BY A HOSPITAL IN AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT SHALL:

(1) INCLUDE AN AFFIDAVIT STATING:

(I) THE DATE ON WHICH THE 180–DAY PERIOD REQUIRED UNDER SUBSECTION (G)(3) OF THIS SECTION ELAPSED AND THE NATURE OF THE NONPAYMENT;

(II) THAT A NOTICE OF INTENT TO FILE AN ACTION UNDER SUBSECTION (I) OF THIS SECTION:

1. WAS SENT TO THE PATIENT AND THE DATE ON WHICH THE NOTICE WAS SENT; AND

2. ACCURATELY REFLECTED THE CONTENTS REQUIRED TO BE INCLUDED IN THE NOTICE;

(III) THAT THE HOSPITAL PROVIDED:

1. THE PATIENT WITH A COPY OF THE INFORMATION SHEET ON THE FINANCIAL ASSISTANCE POLICY IN ACCORDANCE WITH SUBSECTION (I)(3)(II) OF THIS SECTION; AND

2. ~~ORAL NOTICE~~ NOTICE OF THE FINANCIAL ASSISTANCE POLICY AS DOCUMENTED UNDER § 19–214.1(F) OF THIS SUBTITLE;

(IV) THAT THE HOSPITAL MADE A DETERMINATION REGARDING WHETHER THE PATIENT IS ELIGIBLE FOR THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IN ACCORDANCE WITH § 19–214.1 OF THIS SUBTITLE; AND

(V) THAT THE HOSPITAL MADE A GOOD–FAITH EFFORT TO MEET THE REQUIREMENTS OF SUBSECTION (E) OF THIS SECTION; AND

(2) BE ACCOMPANIED BY:

(I) THE ORIGINAL OR A CERTIFIED COPY OF THE HOSPITAL BILL;

(II) A STATEMENT OF THE REMAINING DUE AND PAYABLE DEBT SUPPORTED BY AN AFFIDAVIT OF THE PLAINTIFF, THE HOSPITAL, OR THE AGENT OR ATTORNEY OF THE PLAINTIFF OR HOSPITAL;

(III) A COPY OF THE MOST RECENT HOSPITAL BILL SENT TO THE PATIENT;

(IV) IF THE DEFENDANT IS ELIGIBLE FOR FEDERAL SERVICE MEMBERS CIVIL RELIEF ACT BENEFITS, AN AFFIDAVIT THAT THE HOSPITAL IS IN COMPLIANCE WITH THE ACT;

(V) A COPY OF THE NOTICE OF INTENT TO FILE AN ACTION ON A HOSPITAL BILL; AND

~~**(VI) DOCUMENTATION THAT THE PATIENT HAS ACKNOWLEDGED RECEIPT OF A COPY OF THE INFORMATION REQUIRED TO BE PROVIDED BY THE HOSPITAL UNDER SUBSECTION (I)(3) OF THIS SECTION; AND**~~

~~**(VII) DOCUMENTATION THAT THE HOSPITAL HAS PROVIDED WRITTEN AND ORAL NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY TO THE PATIENT.**~~

(VI) A COPY OF THE PATIENT'S SIGNED CERTIFIED MAIL ACKNOWLEDGMENT OF RECEIPT OF THE WRITTEN NOTICE OF INTENT TO FILE AN ACTION, IF RECEIVED BY THE HOSPITAL.

[(f)**] (K)** If a hospital delegates collection activity to **[**an outside collection agency**] A DEBT COLLECTOR**, the hospital shall:

(1) Specify the collection activity to be performed by the **[**outside collection agency**]** **DEBT COLLECTOR** through an explicit authorization or contract;

(2) Require the **[**outside collection agency**]** **DEBT COLLECTOR** to abide by the hospital's credit and collection policy;

(3) Specify procedures the **[**outside collection agency**]** **DEBT COLLECTOR** must follow if a patient appears to qualify for financial assistance; and

(4) Require the **[**outside collection agency**]** **DEBT COLLECTOR** to:

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

(ii) Forward the complaint to the hospital if a patient files a complaint with the **[**collection agency**]** **DEBT COLLECTOR; AND**

(III) ALONG WITH THE HOSPITAL, BE JOINTLY AND SEVERALLY RESPONSIBLE FOR MEETING THE REQUIREMENTS OF THIS SECTION.

[(g)**]** **(L)** (1) The board of directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital at least every 2 years.

(2) A hospital may not alter its financial assistance or debt collection policies without approval by the board of directors.

[(h)**]** **(M)** The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section.

(N) (1) ~~**THE**~~ **ON OR BEFORE FEBRUARY 1 EACH YEAR, BEGINNING IN 2023, THE COMMISSION SHALL** ~~**PREPARE AN ANNUAL MEDICAL DEBT COLLECTION REPORT THAT IS BASED ON SPECIAL AUDIT PROCEDURE REQUIREMENTS FOR HOSPITALS RELATED TO MEDICAL DEBT**~~ **COMPILE THE INFORMATION REQUIRED UNDER SUBSECTION (A) OF THIS SECTION AND PREPARE A MEDICAL DEBT COLLECTION REPORT BASED ON THE COMPILED INFORMATION.**

(2) THE REPORT REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE:

(I) MADE AVAILABLE TO THE PUBLIC FREE OF CHARGE; AND

(II) SUBMITTED TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) On or before January 1, 2022, the Commission shall develop guidelines, with input from stakeholders, for an income–based payment plan offered under this subsection that includes:

(1) the amount of medical debt owed to the hospital;

(2) the duration of the payment plan based on a patient's annual gross income;

(3) guidelines for requiring appropriate documentation of income level;

(4) guidelines for the payment amount, that:

(i) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income; and

(ii) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article;

(5) guidelines for:

(i) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days after the due date of the first payment; and

(ii) a prohibition on interest payments for patients who qualify for free or reduced–cost care;

(6) guidelines for modification of a repayment plan that does not create a greater financial burden on the patient; and

(7) a prohibition on penalties or fees for prepayment or early payment.

(b) In developing the payment plan guidelines required under subsection (a) of this section, the Health Services Cost Review Commission shall seek input from stakeholders, including the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt.

(c) On or before January 1, 2022, the Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the guidelines required under subsection (a) of this section.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall study the impact on uncompensated care of:

(1) providing for a refund of amounts collected from patients or guarantors of patients who were later found by the hospital to be eligible for reduced–cost care; and

(2) requiring a hospital to forgive a judgment or strike adverse information if a hospital obtains a judgment against, or reports adverse information to a consumer reporting agency about patients who were later found by the hospital to be eligible for reduced–cost care.

(b) (1) In conducting the study required under subsection (a) of this section, if the Health Services Cost Review Commission determines that additional hospital data is required, the Commission shall notify the hospital of the data that is required.

(2) Not later than 30 days after receiving notification from the Commission under paragraph (1) of this subsection, a hospital shall submit the required data to the Commission.

(c) On or before January 1, 2022, the Health Services Cost Review Commission shall report the findings of the study required under subsection (a) of this section to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION 4. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission shall:

(1) examine the feasibility of using the State–designated Health Information Exchange to support the determination of financial status for purposes of determining eligibility for free or reduced–cost care or for an income–based payment plan; and

(2) on or before December 1, 2021, report the findings from the examination required under item (1) of this section to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION ~~2.~~ 5. AND BE IT FURTHER ENACTED, That ~~this Act shall take effect October 1, 2021~~ Sections 2, 3, and 4 of this Act shall take effect June 1, 2021.

SECTION 6. AND BE IT FURTHER ENACTED, That, except as provided in Section 5 of this Act, this Act shall take effect January 1, 2022.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021.