461st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION OF THE

HEALTH SERVICES COST REVIEW COMMISSION

October 14, 2009

9:00 a.m.

1. **Review of the Executive and Public Minutes of September 2, 2009**

2. **Executive Director's Report**

3. **Docket Status - Cases Closed**

2036R - Howard County General Hospital
2037A - Johns Hopkins Health System
2038A - Johns Hopkins Health System
2039A - Johns Hopkins Health System
2040A -MedStar Health
2042A - MedStar Health
2043A - Johns Hopkins Health System
2044A - Johns Hopkins Health System

4. **Docket Status - Cases Open**

2041A - Johns Hopkins Health System
2045A - MedStar Health
2046A - Maryland Physicians Care
2047A - University of Maryland Medical System
2048A - University of Maryland Medical System
2049A - Johns Hopkins Health System

5. **Final Recommendation regarding Options for Methods of Financing Board of Public Works Budget Cuts**

6. **Draft recommendation on the Establishment of Guidelines for NSP II**

7. **Update on Transactions with Related Entities**

8. **Final Recommendation on Handling Charity Care in the Uncompensated Care Provision**

9. **Update on HSCRC Work Group on Patient Financial Assistance and Debt Collection and Related Commission Activity**

10. **Legal Report**

11. **Hearing and Meeting Schedule**

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF OCTOBER 5, 2009

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2041A	Johns Hopkins Health System	8/17/09	N/A	N/A	ARM	DNP	OPEN
2045A	MedStar Health	8/24/09	N/A	N/A	ARM	DNP	OPEN
2046A	Maryland Physicians Care	8/24/09	N/A	N/A	ARM	DNP	OPEN
2047A	University of Maryland Medical System	9/3/09	N/A	N/A	ARM	DNP	OPEN
2048A	University of Maryland Medical System	9/11/09	N/A	N/A	ARM	DNP	OPEN
2049A	Johns Hopkins Health System	9/22/09	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2009**
	*	**FOLIO:**	**1851**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2041A**

Final Recommendation

October 14, 2009

I. Introduction

On August 13, 2009 Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2001A for the period from January 1, 2009 through December 31, 2009. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2010.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider sponsored Managed Care Organization ("MCO" sponsored by the Hospitals), is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics which provide member expertise in the provision of primary care services and assistance in the development of

provider networks on an exclusive basis in exchange for an exclusivity payment.

The application requests approval for the Hospitals to continue to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience and their projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services on a statewide basis and serving almost one-quarter of the state's MCO population.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2001A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff has analyzed Priority Partner's financial history and net income projections for CY 2009 and CY2010. The statements provided by Priority Partners to staff represent both a stand- alone and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. Representatives of Priority Partners have indicated that the data reported on JHHC are exclusive to services, revenues, and costs of the MCO. Moreover, when other MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well.

Staff found that Priority Partners (consolidated) financial performance was favorable in CY 2008 and is expected to continue to be favorable in CY 2009, although profits are expected to decline in CY 2009 and rebound in CY 2010.

IV. Recommendation

As noted above, Priority Partners has shown favorable financial performance on a consolidated basis in CY 2008. While estimates show that Priority Partners consolidated is expected to generate profits in CY 2009, the margin is expected to decline. Based on information currently available on Medicaid rate setting from CY 2010, Priority Partners (Consolidated) is expecting to show favorable performance in CY 2010.

Therefore, staff makes the following recommendations:

1) That approval be granted for participation in the Medicaid Health Choice Program for a one-year period beginning January 1, 2010 with the understanding that sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement;

2) That Priority Partners report to Commission staff (on or before the August 2010 public meeting of the Commission) on the actual CY 2009, preliminary CY 2010, and projected CY 2011 financial performance (adjusted for seasonality) of the MCO;

3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the

understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2009**
	*****	**FOLIO:**	**1855**
COLUMBIA, MARYLAND	*****	**PROCEEDING:**	**2045A**

Final Recommendation

October 14, 2009

I. Introduction

On August 24, 2009, MedStar Health System filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the "Hospitals"). MedStar Health System seeks renewal for the continued participation of MedStar Family Choice in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 1992A for the period from January 1, 2009 through December 31, 2009. The Hospitals are requesting to renew this contract for one year beginning January 1, 2010.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. MedStar Family Choice pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MedStar Family Choice provides services to about 4% of the total number of MCO enrollees in Maryland.

The hospitals supplied information on their most recent experience and their projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 1992A).

Staff reviewed the operating performance of the contract as well as the terms of the capitation pricing agreement. The actual financial experience for CY 2008 was favorable; however, estimates reported to staff for CY 2009 show a negative financial outlook. Medstar Family Choice projects that profitability will rebound in CY 2010.

IV. Recommendation

Staff believes that the proposed renewal arrangement is acceptable under Commission policy. However, staff recommends that further periodic monitoring is necessary to ensure that unfavorable financial performance in CY 2009 does not continue into CY 2010. Staff, nonetheless, believes the CY 2010 projections to be reasonable based on the information currently available regarding Medicaid rate setting for CY 2010.

Staff Recommendations:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2010.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether the expected unfavorable financial performance in CY 2009 does not continue into CY 2010.

(3) Staff recommends that MedStar Family Choice report to Commission staff (on or before the August 2010 meeting of the Commission) on actual experience for CY 2009, the preliminary estimates for CY 2010 financial performance (adjusted for seasonality) of the MCO, and projections for CY 2011.

(4) Consistent with its policy paper outlining a structure for review and evaluation

of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
MARYLAND GENERAL HOSPITAL	*****	**COMMISSION**	
SAINT AGNES HEALTH	*****	**DOCKET:**	**2009**
WESTERN MARYLAND HEALTH SYSTEM	*****	**FOLIO:**	**1856**
WASHINGTON COUNTY HOSPITAL	*****	**PROCEEDING:**	**2046A**

Final Recommendation

October 14, 2009

I. Introduction

On August 25, 2009, Maryland General Hospital, Saint Agnes Health System, Western Maryland Health System, and Washington County Hospital (the "Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care (MPC) in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2003A for the period January 1, 2009 through December 31, 2009. The Hospitals are requesting to renew this contract for one year beginning January 1, 2010.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, in return for a State-determined capitation payment. Maryland Physicians Care pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Maryland Physicians Care provides services to about 17% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2003A).

Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2008, 2009 and 2010. Over the years, the financial performance of MPC has been primarily favorable with the exception of CY 2004, when the MCO experienced a small loss due to unanticipated hospital inpatient cost increases. The actual experience reported to staff for CY2008 was marginally negative as previously expected; however, MPC profits are expected to improve significantly in CY 2009.

IV. Recommendation

MPC has continued to maintain relatively consistent favorable performance in recent years. Staff believes that the proposed renewal arrangement for MPC is acceptable under Commission policy in that the MCO has been able to sustain reasonable profit margins on an overall basis. Staff will closely monitor actual performance to ensure that the favorable results continue into the future.

Therefore, staff recommends the following:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2010 with the understanding that sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement.

(2) Staff recommends that Maryland Physicians Care report to Commission staff (on or before the August 2010 meeting of the Commission) on the actual CY 2009 experience and preliminary CY 2010 financial performance (adjusted for seasonality) of the MCO as well as projections for CY 2011.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2009**
MEDICAL CENTER	*	**FOLIO:**	**1857**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2047A**

Staff Recommendation

October 14, 2009

INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on September 3, 2009 requesting approval to continue to participate in a global rate arrangement for blood and bone marrow transplants for one year with the BlueCross and BlueShield Association Quality Centers for Transplant (BQCT) beginning September 1, 2009. A list of bone marrow transplants provided under this arrangement is attached.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable. Staff is satisfied that the hospital component of the global price has sufficient built-in allowance for inflation to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing September 1, 2009. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document will formalize the understanding between the Commission and the Hospital, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2009**
MEDICAL CENTER	*	**FOLIO:**	**1858**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2048A**

Staff Recommendation

October 14, 2009

I. INTRODUCTION

University of Maryland Medical Center filed an application with the HSCRC on September 11, 2009 requesting approval to continue participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of three years beginning September 1, 2009. A list of transplant services provided under this arrangement is attached.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been marginally unfavorable. However, staff is satisfied that the increased payment rates negoiated with MPC are sufficient to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing September 1, 2009. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2009**
SYSTEM	*	**FOLIO:**	**1859**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2049A**

Staff Recommendation

October 14, 2009

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on September 22, 2009 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services. The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective September 1, 2009.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Health System, the Maryland Department of Health and Mental Hygiene, and the Centers for Medicare and Medicaid Services. The contract covers medical services provided to the PACE population. The assumptions for enrollment, utilization, and unit costs were developed on the basis of historical HEP experience for the PACE population as previously reviewed by an actuarial consultant. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

In prior years, the Maryland PACE Program had been under-funded, which resulted in unfavorable financial performance. However, in February of 2008, DHMH agreed to increase the capitation rate paid to the PACE Program to the national mean capitation rate and to implement the federal PACE provisions regarding the eligibility criteria. These provisions were implemented in order to stabilize and increase the census and to apply the criteria to participants currently in the appeals process. As a result, the program's experience for the fourth quarter of FY2008 and for all of FY 2009 is favorable, and the projected budget shows a continuation of the

favorable performance for FY 2010.

III. STAFF RECOMMENDATION

Based on favorable performance in the last year, staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for one year beginning September 1, 2009.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document formalizes the understanding between the Commission and the Hospital, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Recommendation for an Alternative Method of Financing Board of Public Works July and August Approved Medicaid Day Limits

October 14, 2009

This is a final recommendation and is ready for action by the Commission.

Staff Recommendations for the Funding of July and August 2009 Board of Public Works Budget Cuts (FY 2010)

Issue/Background

In July, 2009, The Board of Public Works (BPW) imposed budgetary cuts resulting in $8.9 million in State General Fund Savings through either the re-implementation of Medicaid Day Limits (MDLs) effective January 1, or an ***alternative approach*** by the HSCRC to generate the same amount of State General Fund Savings.

The use of the Assessment/Remittance approach has some distinct advantages over the imposition of Medicaid Day Limits. These advantages were described in the staff's Final Recommendation presented in September.[1]

In August, 2009, BPW also imposed additional cuts resulting in $4.5 million in State General Fund Savings through MDLs or an alternative approach approved by the HSCRC to generate the same amount of State General Fund Savings.

As stated in the BPW action – there are two ways to generate the required cuts: 1) through imposition of Medicaid Day Limits (reduced payments from Medicaid to hospitals for each case up to some specified limit); or 2) through an ***alternative approach***: e.g., staff's approach of applying an assessment on rates and requiring a remittance of funds from hospitals to Medicaid directly (referred to as the Assessment/Remittance option).

In September, the Commission approved recommendations to pursue the ***alternative approach*** and impose a hospital assessment of $8.9 million (and remittance of that $8.9 million by hospitals to Medicaid) to achieve the State General Fund Savings.

After some discussion however, the Commission also asked staff to consider options for handling the August and potential future cuts. Staff has considered various options for addressing both the July and August cuts as well as options regarding possible future cuts by the State. From these options the staff has developed a set of final recommendations for the Commission.

1 – Funding Options Considered by Staff

[1] They include: uniform assessment is more equitable; HSCRC retains control over whether to impose an assessment and is not subject to DHMH decisions year to year; administratively simple to implement; savings will be known; allows Medicaid to receive the federal match.

Base line Option #1 - Use of Medicaid Day Limits (not recommended – discussed for comparison purposes only).

This option would impose MDLs to achieve the savings (for just August or both July and August cuts). Using MDLs to fund the cuts results in payment cuts to hospitals far in excess of the required State imposed cuts. This is because the State's share of Medicaid payments is now approximately 41%. Thus, in the case of the July cuts, to generate $8.9 million in State savings, MDLs would need to generate $23 million in payment cuts to hospitals. To generate State funds sufficient to cover both the July and August cuts ($8.9 million in July and $4.5 million in August), MDL payment cuts would need to be $34 million.

As discussed in the Staff's final recommendation in September, there are also a number of administrative and equity disadvantages associated with the use of MDLs.

Option #2 – Assessment/Remittance approach for both July and August Cuts: 100% Payer/0% Hospital

This option extends the recommendations adopted by the Commission for the July cuts ($8.9 million) to the August cuts ($4.5 million). Under this approach, the HSCRC would assess the combined amounts ($13.4 million) on rates paid by payers. Hospitals then would collect these extra revenues and be required to remit $13.4 million to Medicaid. Under this approach, 100% of the required cut is funded by payers and patients, and 0% is funded by hospitals. This approach would require additional action by the HSCRC to revise the action taken at the September Commission meeting.

Implications: Shifts full amount of the cuts to payers (including some proportion to Medicaid – resulting in a diminishment of the savings the State intends to achieve); hospitals do not share in the burden of funding these cuts; and diminishes the savings to the State by $864,417 because 100% is financed through an assessment to all payers (including Medicaid).

Option # 3 – Assessment/Remittance approach: Payers and Hospitals share in these cuts 50/50%

This option would take the sum of the July and August cuts and split the burden in half. Under this option – the HSCRC would place an assessment of $6.7 million (instead of the $8.9 million previously approved in September) in the form of higher rates, and hospitals would be required to remit to Medicaid the additional $6.7 million plus $6.7 million of their own money. This approach

would require additional action by the HSCRC to revise the action taken at the September Commission meeting.

Implications: equal sharing of burden of State cuts between hospitals and payers; less of a dilution of State savings because of assessment (Medicaid's share of the $6.7 million assessment would be $432,208).

Option #4 – Approve the recommendation for an assessment with commensurate rate increase for the July cut ($8.9 million) and for the August cut ($4.5 million) - results in a 66/34% split between Payers and Hospitals respectively in sharing this burden

This option would retain the Commission's September approval of the recommendation for an assessment with the increase for the July cuts ($8.9 million), but would have the hospitals fund the August cuts ($4.5 million) directly. Hospital rates would be raised by an assessment of $8.9 million. Hospitals would be required to remit to the Medicaid program a total of $13.4 million ($8.9 million + $4.5 million).

Implications: Builds on the September Commission action, but results in some sharing of the burden of funding the cuts; results in a dilution of State savings of $572,694 (**see Exhibit 1**).

2 – Funding of Future Cuts

Option #1 – Assessment/Remittance Option but require all future cuts to be financed directly by hospitals

HSCRC to leave it up to hospitals to remit any additional cuts (beyond the July and August cuts) directly to Medicaid – or if they refuse – allow Medicaid to implement the much more onerous Day Limit cut sufficient to generate the additional savings.

Implications: Reduces hospital profitability, but also incentivizes the industry to resist further cuts. Also results in no further dilution in Medicaid savings.

Option #2 – Assessment/Remittance Option but fund future cuts in the same proportion as that adopted by the Commission for the July and August cuts.

If the HSCRC opted for the 50/50% Payer/Hospital sharing split, all further cuts would be funded through equal-part assessments on rates (and commensurate remittance) and equal-part additional remittance by hospitals.

Implications: Reduces hospital profitability (by a lesser amount), but also incentivizes the industry to resist further cuts (by a lesser amount). Continuation of a split in funding would also dilute Medicaid savings at the same rate contained within sharing option selected by the Commission (**see Exhibit 1**).

Final Staff Recommendation

Based on the analysis above, the staff would recommends the following action related to the funding of the July and August 2009 Board of Public Work budget cuts and potential future budget cuts during the course of FY 2010:

Option 4 shown in Exhibit 1: Consistent with the Commission's September action, impose a uniform assessment on hospital rates of $8.9 million associated with the July Board of Public Works (BPW) approved budget cut for FY 2010, but require that Maryland hospitals remit a total of $13.4 million to the State Medicaid program (associated with both the July and August BPW approved cuts). This results in a 66/34% split in the sharing of this burden between Payers ($8.9 million funded through the assessment) and Hospitals ($4.5 million funded directly by hospitals).

Impact of Medicaid Day Limits

Alternative Approaches

Exhibit 1

Note 1: Option 1 - Allows Medicaid Day Limits to be implemented while ensuring that MDL is not reflected in the UCC policy.

Line		A	B	C	D	E	F	G	H
3	**Option 2: Payer- Hospital Split**		**NOTE 1**	**100.00%**	**0.00%**				Hospital Savings
4			Industry	Payer Assessed	Hospital	Hospital Payment	Federal	Medicaid	Compared to
5			Total	Rate Increase	Cost	To Medicaid	Matching Funds	Payments	Option 1
6	July 22, 2009 Approved Reduction		-$23,165,113	$8,897,720	$0	$8,897,720	$14,267,393	$23,165,113	$23,165,113
8	August 2009 Approved Reduction		-$11,800,000	$4,532,380	$0	$4,532,380	$7,267,620	$11,800,000	$11,800,000
9	Total Reduction		-$34,965,113	$13,430,100	$0	$13,430,100	$21,535,013	$34,965,113	$34,965,113
11	Est. Net Operating Revenue FY 2010		$11,637,000,000						
12	Impact on Operating Margin		-0.30%		0.00%				0.30%
13	Medicaid Fee For Service Share			$864,417 Net Medicaid Cost					
15	**Option 3: Payer- Hospital Split**			**50.00%**	**50.00%**				Hospital Savings
16			Industry	Payer Assessed	Hospital	Hospital Payment	Federal	Medicaid	Compared to
17			Total	Rate Increase	Cost	To Medicaid	Matching Funds	Payments	Option 1
18	July 22, 2009 Approved Reduction		-$23,165,113	$4,448,860	-$4,448,860	$8,897,720	$14,267,393	$23,165,113	$18,716,253
20	August 2009 Approved Reduction		-$11,800,000	$2,266,190	-$2,266,190	$4,532,380	$7,267,620	$11,800,000	$9,533,810
21	Total Reduction		-$34,965,113	$6,715,050	-$6,715,050	$13,430,100	$21,535,013	$34,965,113	$28,250,063
23	Est. Net Operating Revenue FY 2010		$11,637,000,000						
24	Impact on Operating Margin		-0.30%		-0.06%				0.24%
25	Medicaid Fee For Service Share			$432,208 Net Medicaid Cost					
27	**Option 4: Payer- Hospital Split**			**66.25%**	**33.75%**				Hospital Savings
28	**Staff Recommended Option**		Industry	Payer Assessed	Hospital	Hospital Payment	Federal	Medicaid	Compared to
29			Total	Rate Increase	Cost	To Medicaid	Matching Funds	Payments	Option 1
30	July 22, 2009 Approved Reduction		-$23,165,113	$8,897,720	$0	$8,897,720	$14,267,393	$23,165,113	$23,165,113
32	August 2009 Approved Reduction		-$11,800,000	$0	-$4,532,380	$4,532,380	$7,267,620	$11,800,000	$7,267,620
33	Total Reduction		-$34,965,113	$8,897,720	-$4,532,380	$13,430,100	$21,535,013	$34,965,113	$30,432,733
35	Est. Net Operating Revenue FY 2010		$11,637,000,000						
36	Impact on Operating Margin		-0.30%		-0.04%				0.26%
37	Medicaid Fee For Service Share			$572,694 Net Medicaid Cost					
40	**Example of 50/50 sharing**								Hospital Savings
41	**of potential Future Cuts**		Industry	Payer Assessed	Hospital	Hospital Payment	Federal	Medicaid	Compared to
42			Total	Rate Increase	Cost	To Medicaid	Matching Funds	Payments	Option 1
43	July 22, 2009 Approved Reduction		-$23,165,113	$8,897,720	$0	$8,897,720	$14,267,393	$23,165,113	$23,165,113
45	August 2009 Approved Reduction		-$11,800,000	$0	-$4,532,380	$4,532,380	$7,267,620	$11,800,000	$7,267,620
46				**50.00%**	**50.00%**				
47	Future Approved Reduction		-$20,000,000	$3,841,000	-$3,841,000	$7,682,000	$12,318,000	$20,000,000	$16,159,000
48	Total Reduction		-$54,965,113	$12,738,720	-$8,373,380	$21,112,100	$33,853,013	$54,965,113	$46,591,733
50	Est. Net Operating Revenue FY 2010		$11,637,000,000						
51	Impact on Operating Margin		-0.47%		-0.07%				0.40%
52	Medicaid Fee For Service Share			$819,917 Net Medicaid Cost					

Draft Recommendation:

The Establishment of Guidelines for the Nurse Support Program II

October 14, 2009

This is a draft recommendation to the Commission. Any comments regarding these recommendations may be sent to Oscar Ibarra on or before October 28, 2009

NURSE SUPPORT PROGRAM II GUIDELINES

Section 11-405(e) of the Education Article of the Annotated Code of Maryland provides that Nurse Support Program II (NSPII) funds shall be used in accordance with guidelines established by the Health Services Cost Review Commission and the Maryland Higher Education Commission. This Recommendation establishes the guidelines for the NSPII program.

A. PURPOSE

The Health Services Cost Review Commission (HSCRC) approved the creation of the Nurse Support Program II (NSP II) on May 4, 2005, in order to alleviate the critical shortage of qualified nurses in Maryland by expanding the capacity of Maryland nursing schools. The program is scheduled to be funded for up to ten years by a 0.1% increase to regulated gross patient revenue. NSP II focuses on expanding the capacity to educate nurses, with specific attention given to educating nurses to become faculty members.

B. ADMINISTRATION

The HSCRC contracted with the Maryland Higher Education Commission (MHEC) to administer NSP II, which includes developing applications and guidelines, overseeing the review and selection of applicants, conducting site visits, and monitoring and evaluating NSP II. MHEC provides the programmatic and administrative support necessary for the successful administration of the NSP II program. MHEC is compensated an agreed-upon amount from NSP II funds each year to perform its administrative duties.

C. NSP II Program Description

Under Nurse Support Program II, two components are authorized:

1) Competitive Institutional Grants
2) Statewide Initiatives (which include)
    a. Graduate Nursing Faculty Scholarship
    b. Living Expenses Grant
    c. New Nursing Faculty Fellowship
    d. Loan Assistance Repayment for New Nursing Faculty

Competitive Institutional Grants

Competitive Institutional Grants are awarded to eligible applicants consisting of: 1) a consortia of Maryland institutions of higher education with nursing degree programs and Maryland hospitals; 2) individual Maryland higher education institutions with nursing degree programs; or 3) partnerships of Maryland higher education institutions with nursing degree programs through a competitive Request for Applications process. The

size of each Competitive Institutional Grant award will depend upon the grant project's ability to impact the nursing shortage in a timely manner, the depth and breadth of the initiative, and the feasibility of the budget.

In the annual Request for Applications, MHEC, in consultation with HSCRC staff, will designate initiatives that are eligible for funding. In FY 2010, allowable initiatives included:

- Initiatives to expand Maryland's nursing capacity through shared resources of schools of nursing and hospitals, allowing for immediate expansion of nursing enrollments and graduates.

- Initiatives to increase Maryland's nursing faculty through the implementation of sustainable strategies to increase the supply of nursing faculty by increasing enrollments and enhancing or creating graduate nursing programs.

- Initiatives to increase nursing student retention through strategies such as tutoring, mentoring, on-line testing.

- Initiatives to increase the pipeline for nursing faculty by increasing the proportion of students entering community colleges who transition into baccalaureate degree programs immediately after completion of community college.

- Initiatives to increase capacity statewide through development of innovative statewide programs in areas such as faculty development, simulation training, student retention, preceptor training.

MHEC will establish a review panel to evaluate all applications and make recommendations regarding the selection of proposals that best meet established goals for this program. Each proposal will be evaluated based on the criteria described in the proposal narrative section and summarized below. The rating given for each criterion will serve as a significant, but not exclusive aspect of the judgment made by the review panel. State priorities, support of diversity, and regional needs will also be taken into consideration. The panel also makes recommendations on the level of funding and adjustments that the project staff might make to improve the project. The recommendations of the review panel will be presented to the HSCRC, which will make the final determination.

Projects may range from three to five years. MHEC, in collaboration with the staff of the HSCRC, reserves the right to request changes to the original plan and the right to end the grant if deemed necessary.

Grantees may wish to request changes to the original plan once a project is underway. Approval must be received from MHEC before such changes are made.

Annual progress reports are required each year.

Statewide Initiatives

Statewide Initiatives provide funding to individual students and faculty using application processes. The authorized initiatives are:

- *Graduate Nursing Faculty Scholarships* are available to eligible students who are sponsored by Maryland higher education institutions to complete the graduate education necessary to become qualified nursing faculty at Maryland institutions.

  The maximum total award per graduate student is $26,000 for tuition and fees. Students may receive up to $13,000 per year, which is pro-rated for part-time students. Recipients must sign a promissory note pledging to work as nursing faculty after receiving their graduate degrees or must repay the scholarship. The number of awards is dependent upon the number of applications and availability of funds.

- *Living Expenses Grants* are awarded to those recipients of the Graduate Nursing Faculty Scholarship who show need through submission of federal tax returns and W-2s. Awards may total $50,000 per applicant over the course of graduate studies, with a maximum of $25,000 per year.

- *New Nursing Faculty Fellowships* are provided to eligible, recently-hired nursing faculty members. Maryland institutions may nominate any number of newly-hired (within the past year) full-time, tenure-track faculty. Full-time clinical-track faculty who have a long-term contract with a Maryland school of nursing also may be eligible.

  The maximum award amount is $20,000, with $10,000 distributed the first year, and $5,000 distributed in each of the following two years, provided the faculty member is still employed in good standing. These funds must not replace any portion of the nursing faculty fellow's regular salary, but may be used as a supplement or to assist fellows with professional expenses, such as loan repayment, professional development, and other relevant expenses. The number of awards is dependent upon the number of nominations and the availability of funds.

- *Loan Assistance Repayment Program (through the Janet L. Hoffman Loan Assistance Repayment Program)* is for Maryland residents who are nursing faculty. Awards are determined by applicants' overall reported educational debt at the time of application. Applicants will be ranked according to graduation date and then application date. Priority is given to individuals who have graduated from an institution of higher education in the last three years.

  The awards are based on each applicant's overall reported educational debt. Award funds are distributed over three years provided the recipient remains eligible and submits required documentation.

D. Continuing Non-lapsing Special Fund

Legislation was enacted to create a non-lapsing special fund that is not subject to Section 7-302 of the State Finance and Procurement Article. The NSPII fund shall consist of revenue generated through an increase to rates of all Maryland hospitals, as approved by the HSCRC. Any interest earned on the fund shall be paid into the fund and shall not revert to the General Fund.

These NSP II Special Funds may only be used for authorized NSP II initiatives, including grants and awards as designated and approved by the HSCRC and MHEC.

Recommendation

Staff recommends approval of these guidelines to comply with the provisions of Section 11-405(e) of the Education Article of the Annotated Code of Maryland. If adopted, the Commission will submit the approved guidelines to the Maryland Higher Education Commission for final approval.

Analysis of Transactions Between Hospitals and Related Entities

October 14, 2009

TRANSACTIONS WITH RELATED ENTITIES

In 1989, the Health Services Cost Review Commission (HSCRC) required hospitals to report, on an annual basis, financial transactions with related entities. This policy was adopted in response to the recommendations made by a joint HSCRC and Maryland Hospital Association committee established to study the financial condition of Maryland hospitals. The committee was addressing the issue of whether less funds would be available to hospitals as a result of corporate reorganization. The committee recommended that a schedule be developed to report financial transactions between hospitals and related entities.As a result, the TRE schedule was developed in 1990 to allow this information to be summarized and reported in a logical and consistent fashion.[1]

It is important to understand what effect, if any, the transactions between hospitals and related entities may have on both the rates hospitals are permitted to charge and their financial condition. To a very large extent, transactions involving related entities have no impact whatsoever upon the rates charged by hospitals. Each year, a hospital's rates may be changed by one of two methods: the annual update, or a full rate review. The annual update is the method by which most hospitals have their rates adjusted each year. The annual update does not consider expenses of particular hospitals in establishing the rates from one year to the next. A principal incentive of a prospective payment system is to encourage hospitals to become more efficient. Adjusting a hospital's rates by using factors that are not directly related to the expenses of the institution means that as a hospital lowers its own costs, it is permitted to keep the difference between the rates charged and its costs. Conversely, if a hospital becomes less

[1] Virtually all of this information can be found in notes to hospitals' audited financial statements.

productive, that is, if its actual expenses increase faster than the reasonable inflation provisions, the public will still pay only those rates that have been deemed reasonable.

It is only during the course of a full rate review, when the entire cost structure of a hospital is examined, that the expenses involved in these related entity transactions may be considered by the HSCRC. Even at that point, the effect of a transaction by any one hospital would not necessarily be incorporated into the rates for that institution. This is because the HSCRC's methodology includes standards of reasonableness based on the average performance of a peer group of institutions. If the transaction results in higher costs than the peer group average, the costs will be deemed unreasonable. If the transaction results in lower costs, hence a more efficient performance, the hospital should be commended.

The effect of these transactions on the financial condition of Maryland hospitals is somewhat more difficult to ascertain. All of these transactions will influence, in one way or another, the financial statements of hospitals. In the vast majority of cases, these transactions are the result of hospitals responding to the incentives of the HSCRC rate system. For example, hospitals that are part of multi-hospital systems may purchase centralized services from a parent corporation in order to achieve efficiencies resulting from economies of scale. Transactions involving loans, working capital, equity investments, and grants or gifts must be viewed perhaps more carefully. It is important, for example, to consider the flow of these transactions over time. In addition, the circumstances at each hospital differ and, as a result, even summary information of a particular institution must be analyzed in greater detail.

Each transaction reported was classified into the following categories:

Category Code	Category Description
1	Related entity has **purchased** services or staff support (includes benefit costs) from the hospital.
2	Hospital has **purchased** services or staff support (includes benefit costs) from the related entity.
3	Related entity has **purchased** supplies or other non-capital related items from the hospital.
4	Hospital has **purchased** supplies or other non-capital related items from the related entity.
5	Related entity has **purchased** office space or equipment from the hospital.
6	Hospital has **purchased** office space or equipment from the related entity.
7	Hospital has **provided** a loan, loan repayment, working capital, or equity investments to the related entity.
8	Related entity has **provided** a loan, loan repayment, working capital, or equity investments to the hospital.
9	Hospital has **provided** a grant or gift to the related entity.
10	Related entity has **provided** a gift or grant to hospital.

Even these classifications were found to be too numerous to analyze with any degree of cohesion. For that reason, the transactions were further collapsed into two broad categories. The first broad category (including category codes 1 – 6) related to transactions involving **purchases** of services, supplies, office supplies, and land or equipment. Hereafter, this broad category is referred to as **Group I Transactions.**

The second broad category (including category codes 7 – 10) related to transactions involving the **provision** of loans, working capital, equity investments, and grants or gifts. This grouping of transactions is referred to as **Group II Transactions.**

Financial transactions between two parties can go in two directions. For example, a hospital may purchase data processing services from a related organization, or a related entity can make a loan to the hospital. For purposes of this study, transactions labeled "TO THE HOSPITAL" involve goods, services, or loans provided to a hospital by a related entity.

On the other hand, a related organization may purchase laboratory services from the hospital, or the hospital may make a loan to the related entity. For the purposes of this study, transactions labeled "FROM THE HOSPITAL" involve goods, services, or loans provided by a hospital to a related entity.

Findings

Included below is a three year analysis (years 2006 – 2008) of information submitted by Maryland hospitals to the HSCRC on TRE schedules. The analysis is divided into three subsections. The first analysis is of Group I transactions--those involving **purchases** of services, supplies, office space, and land or equipment. The second subsection analyzes Group II transactions--those involving the **provision** of loans, working capital, equity investments, and grants or gifts. The final subsection summarizes this information for both groups of transaction.

A. Group I Transactions - Purchases of Services, Supplies, Office Space, Land or Equipment.

In 2008, hospitals purchased $590.8 million in services, supplies, office space, land, or equipment from related entities (Group I Transactions). At the same time, related entities purchased $139.5 million in Group I Transactions from hospitals. For the three year study period, hospitals purchased $1.6 billion from related entities. For the three year study period, related entities purchased $685.3 million from hospitals (See Exhibit A).

Group I Transactions involving purchases by hospitals from related entities increased by 11.2 % from 2006 to 2007 and by 10.2% from 2007 to 2008, while Group I transactions involving purchases by related entities from hospitals increased by 18.2% from 2006 to 2007 and by 10.1% from 2007 to 2008. The increases for the period from 2006 through 2008 were 22.5% and 30.2% respectively (See Exhibit B).

For each of the three years, there were more services purchased by hospitals from related entities than related entities purchased from hospitals.

Over the three-year study, 39 hospitals had at least one Group I Transaction. Exhibit B summarizes Group I Transactions by year and by hospital.

In 2008, hospitals in multi-hospital systems purchased $514.4 million in Group I Transactions from related entities. At the same time, related entities purchased $226.6 million in Group I Transactions from hospitals in multi-hospital systems. In 2008, Group I Transaction purchases by hospitals in multi-hospital systems from related entities were 87.1% of all Group I Transactions, while purchases by related entities from hospitals in multi-hospital systems were 88.5% of all Group I Transactions. For the three year study period, hospitals in multi-hospital systems purchased $1.4 billion in Group I Transactions from related entities, while related entities purchased $589.3 million in Group I Transactions from hospitals in multi-hospital systems (See Exhibit E).

During the period of the study, 2006 through 2008, Group I Transaction purchases by hospitals in multi-hospital systems from related entities grew at approximately the same rate as all hospitals, 21.9%, while Group I Transaction purchases by related entities from hospitals in multi-hospital systems actually grew at a slightly faster rate 38.4%, (See Exhibit E).

B. Group II Transactions – The Provision of Loans, Working Capital, Equity, Investments, Grants or Gifts

In 2008, hospitals benefited from loans, working capital, equity contributions, investments, grants, or gifts (Group II Transactions) provided by related entities in the amount of $139.5 million, while related entities benefited by $196.6 million in Group II Transactions provided by hospitals. For the three year period, hospitals benefited by $269.1 million in Group II Transactions provided by related entities, while related entities benefited by $439.5 million in Group II Transactions provided by hospitals (See Exhibit A).

Group II Transactions benefiting hospitals increased by 60.4% from 2006 to 2007 and by 74.8% from 2007 to 2008, while Group II Transactions benefiting related entities increased by 17.8% from 2006 to 2007 and by 49.6% from 2007 to 2008. The increases for the period from 2006 through 2008 were 180.4% and 76.2% respectively (See Exhibit C).

In 2008, hospitals in multi-hospital systems benefited by $75.1 million in Group II Transactions from related entities, while related entities benefited by $6.5 million in Group II Transactions from hospitals in multi-hospital systems. In 2008, Group II Transactions benefiting hospitals in multi-hospital systems were 53.8% of all Group II transactions, while Group II Transactions benefiting related entities were 3.3% of all Group II transactions. For the three year study period, hospitals in multi-hospital systems benefited by $157.8 million in Group II Transactions from related entities, while related entities benefited by $58.2 million in Group II Transactions from hospitals in multi-hospital systems.

During the period of the study, 2006 through 2008, Group II Transactions benefiting hospitals in multi-hospital systems grew at a rate of 137.2%, while Group II Transactions benefiting related entities declined markedly, -79.6%. In total, Group II Transactions benefiting hospitals in multi-hospital systems exceeded Group II Transactions benefiting related entities by $99.4 million (See Exhibit F).

In all three years of the study period, there were more Group II Transactions benefiting related entities than benefiting hospitals. (See Exhibit C).

In 2008, 25 hospitals reported Group II Transactions. Over the three year study period, 26 hospitals had at least one Group II transaction for one of the study years. Exhibit C summarizes Group II Transactions by year and by hospital.

Summary of All Transactions

Forty-four facilities reported at least one type of transaction during the period 2006 through 2008. In aggregate, hospitals purchased and received the benefit of $730.3 million in Group I and II Transactions in the latest year (2008), and, in turn, related entities purchased and received the benefit of $452.7 million in Group I and II Transactions-- a net difference of $277.7 million. For all three years, the value of transactions where hospitals purchased or benefited was

greater than where related entities purchased or benefited (See Exhibit A).
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For the three year period the total value of Group I and II Transactions involving purchases by hospitals or transactions that benefited hospitals ($1.9 billion) was greater than the total value of such transactions involving purchases or transactions that benefited related entities ($1.1 billion) by $753.3 million (See Exhibit A). To place this in context, the related party transactions for the three year period was 10% of all hospitals' net operating revenue.

Eight Maryland multi-hospital systems comprised of 23 hospitals, account for $1.8 billion or 61.1% of the value of all transactions for the three year period. If the 4 single hospitals that are members of out-of-state hospital systems are included, the 27 Maryland hospitals in hospital systems account for $2.5 billion or 82.4% of all transactions while representing up 52% of hospitals reporting transactions. To place this in context, the related party transactions of the 27 multi-hospital system hospitals for the three year period was 7.8% of their net operating revenue.

Final Recommendation on Handling Charity Care in the Uncompensated Care Provision

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(410) 764-2605

October 14, 2009

This recommendation is ready for Commission action.

Purpose

The purpose of this recommendation is to incentivize Maryland hospitals to provide more charity care and to appropriately report to the Commission just how much charity care they provide. The problems highlighted by the *Baltimore Sun* articles on Maryland hospitals and uncompensated care prompted the legislature to enact legislation that allows the Commission to establish thresholds higher than 150% of the Federal Poverty Level (FPL) and to take into account patient mix, financial condition, level of bad debt, and level of charity care in establishing those thresholds.

Over the past few months, the Commission staff has been working on a broad range of possible measures that can be used to account for the level of Charity Care in the Uncompensated Care Provision built into rates for Maryland hospitals. Staff completed its work in June 2009.

Model

The model for the Uncompensated Care remains as specified in the current methodology with all its attendant computations. However, the amount of uncompensated care in rates before the 100% Pooling Level is established would be computed as follows:

1. Take the current policy results by hospital and make the charity care adjustments to them (Charity care adjustment is calculated as a fraction of the percent of hospital gross patient revenue that is Charity Care); and

2. Calculate the revenue neutrality adjustment as a proportional adjustment to neutralize the impact of the charity care adjustment and adjust the statewide Uncompensated Care Provision to the appropriate level.

Data Analysis and Result

Staff has performed analysis based on the approach described above. The results of this modeling are presented in Tables 1 and 2. The results show that hospitals whose ratio of charity care to current policy results exceeds the statewide ratio will receive positive charity care adjustments while, conversely, hospitals whose ratio of charity care to current policy results is less than the statewide ratio will receive negative charity care adjustments.

Public Comments on the Draft Recommendation

During the comment period that ended October 2, 2009, staff received three comment letters. The letters are attached to the appendix section of this document. The letters are from the Maryland Hospital Association, the University of Maryland Medical System (UMMS), and Dr. Hal Cohen on behalf of CareFirst BlueCross BlueShield and Kaiser Permanente. While the comment letters were generally supportive of the idea behind the draft proposal -- that charity care is preferable to bad debts for patients who cannot afford to pay their hospital bills -- concerns were raised about the implementation date and the data period to be used for the calculation of the charity care adjustment.

The letter from the UMMS also raised questions about the magnitude of the charity care adjustment, the clarity of "the mechanics of the process," and the stability of the model over time. The letter further suggested that a more straightforward and transparent method be used to modify the current policy, and that possible alternatives to the recommendation be explored.

Staff acknowledges the common belief and practice among various participants within the Maryland hospital industry that data elements and the reporting of those elements are given higher priority when they directly affect hospital rates. However, staff believes that without a specific and clear implementation date for this proposal, the data needed by the Commission to evaluate the charity care provision by Maryland hospitals will continue to be reported erroneously to the Commission, since there is no incentive for accurate reporting.

Staff agrees with the commentators that FY 2010 data be used instead of FY 2009 data in the calculation of the charity care adjustment. Staff also agrees that the implementation date be moved to July 1, 2011 (rate year 2012).

In response to UMMS's suggestion of possible alternatives to the recommended charity care adjustment as outlined in the model section of this document, staff agrees that if there is a more straightforward and transparent method of adjusting for charity care within the current Uncompensated Care Methodology, that the hospitals and their representatives should share them with staff and the industry for evaluation. The staff has not yet been presented with any alternative calculations to the charity care adjustment proposed.

Recommendation

The staff recommends that the Commission change its method for calculating prospective levels of uncompensated care for Maryland hospitals by adding charity care adjustments to the existing methodology. The new method would be effective July 1, 2011 (rate year 2012) and will use data submitted for fiscal year 2010.

Table 1
Difference Between Current Policy and Proposed Policy Results for FY 2012

Hospid	Hospital Name	Actual UCC	Percent of Gross Patient Revenue that is Charity Care	Current Policy Results	Proposed Policy Results	Difference	Ratio of charity care to Current Policy Result	Proposed greater than current policy result
210017	Garrett County Memorial Hospital	9.30%	5.47%	7.71%	8.31%	0.61%	71.01%	1
210029	Johns Hopkins Bayview Med. Center	9.36%	5.16%	8.87%	9.35%	0.48%	58.20%	1
210018	Montgomery General Hospital	5.55%	3.92%	6.72%	7.09%	0.37%	58.23%	1
210011	St. Agnes Hospital	6.24%	3.53%	7.16%	7.43%	0.27%	49.25%	1
210001	Washington County Hospital	7.99%	3.55%	7.42%	7.68%	0.26%	47.79%	1
210027	Braddock Hospital	4.75%	2.41%	4.75%	4.94%	0.19%	50.77%	1
210002	Univ. of Maryland Medical System	9.48%	3.75%	9.71%	9.88%	0.17%	38.59%	1
210045	McCready Foundation, Inc.	10.27%	3.39%	8.93%	9.07%	0.14%	38.00%	1
210057	Shady Grove Adventist Hospital	6.66%	2.84%	7.63%	7.74%	0.11%	37.29%	1
210025	The Memorial Hospital	5.48%	2.25%	5.64%	5.75%	0.11%	39.91%	1
210033	Carroll County General Hospital	5.64%	2.32%	5.91%	6.02%	0.11%	39.19%	1
210004	Holy Cross Hospital of Silver Spring	7.37%	2.46%	6.85%	6.94%	0.08%	35.88%	1
210009	Johns Hopkins Hospital	6.08%	2.25%	6.22%	6.30%	0.08%	36.20%	1
210016	Washington Adventist Hospital	9.98%	2.90%	8.60%	8.67%	0.07%	33.69%	1
210019	Peninsula Regional Medical Center	6.50%	2.16%	6.11%	6.18%	0.07%	35.26%	1
210028	St. Marys Hospital	6.29%	2.62%	7.75%	7.81%	0.06%	33.79%	1
210024	Union Memorial Hospital	6.93%	2.27%	6.66%	6.72%	0.06%	34.17%	1
210008	Mercy Medical Center, Inc.	7.41%	2.56%	7.77%	7.83%	0.05%	32.94%	1
210007	St. Josephs Hospital	3.36%	1.06%	3.27%	3.28%	0.02%	32.48%	1
210022	Suburban Hospital Association,Inc	5.04%	1.55%	5.12%	5.12%	0.01%	30.34%	1
210013	Bon Secours Hospital	17.08%	4.64%	15.74%	15.75%	0.00%	29.47%	1
210005	Frederick Memorial Hospital	5.62%	1.86%	6.35%	6.35%	-0.00%	29.23%	0
210015	Franklin Square Hospital	8.09%	2.51%	8.56%	8.56%	-0.00%	29.28%	0
210030	Chester River Hospital Center	11.90%	2.31%	8.28%	8.25%	-0.02%	27.86%	0
210040	Northwest Hospital Center, Inc.	7.97%	2.20%	8.07%	8.04%	-0.03%	27.22%	0
210023	Anne Arundel General Hospital	4.68%	1.12%	4.77%	4.71%	-0.05%	23.50%	0
210012	Sinai Hospital	8.03%	1.91%	7.60%	7.54%	-0.06%	25.15%	0
210056	Good Samaritan Hospital	5.80%	1.41%	5.98%	5.91%	-0.07%	23.53%	0
210061	Atlantic General Hospital	5.48%	1.36%	5.97%	5.90%	-0.08%	22.70%	0
210044	Greater Baltimore Medical Center	2.81%	0.39%	3.41%	3.29%	-0.12%	11.38%	0
210039	Calvert Memorial Hospital	5.72%	1.24%	6.64%	6.50%	-0.13%	18.65%	0
210049	Upper Chesepeake Medical Center	5.90%	1.00%	6.14%	5.98%	-0.15%	16.32%	0
210043	North Arundel General Hospital	7.94%	1.33%	7.83%	7.65%	-0.18%	17.01%	0
210037	Memorial Hospital at Easton	5.71%	0.60%	5.92%	5.71%	-0.21%	10.21%	0
210034	Harbor Hospital Center	8.94%	1.75%	9.87%	9.66%	-0.22%	17.76%	0
210048	Howard County General Hospital	5.21%	0.66%	6.22%	5.99%	-0.22%	10.56%	0
210032	Union Hospital of Cecil County	7.76%	1.09%	8.28%	8.02%	-0.25%	13.15%	0
210035	Civista Medical Center	7.43%	0.78%	7.28%	7.02%	-0.26%	10.75%	0
210010	Dorchester General Hospital	5.97%	1.06%	8.41%	8.14%	-0.27%	12.55%	0
210006	Harford Memorial Hospital	11.95%	1.40%	9.59%	9.32%	-0.27%	14.54%	0
210058	James Lawrence Kernan Hospital	6.22%	0.50%	6.58%	6.31%	-0.27%	7.60%	0
210054	Southern Maryland Hospital	9.49%	0.68%	8.47%	8.12%	-0.34%	8.04%	0
210060	Fort Washington Medical Center	14.20%	1.40%	11.78%	11.39%	-0.39%	11.85%	0
210051	Doctors Community Hospital	10.88%	0.43%	9.84%	9.38%	-0.47%	4.36%	0
210038	Maryland General Hospital	12.71%	0.78%	12.56%	12.01%	-0.55%	6.23%	0
210055	Laurel Regional Hospital	12.63%	0.28%	11.27%	10.70%	-0.57%	2.50%	0
210003	Prince Georges Hospital	14.93%	0.61%	14.19%	13.51%	-0.67%	4.31%	0
	STATE-WIDE	7.39%	2.17%	7.39%	7.39%	-0.00%	29.41%	

Table 2

Policy Results from the Regression, Charity Care Adjustment and Revenue Neutrality Adjustment for FY 2012

Hospid	Hospital Name	UCC in Rates	Actual UCC	Predicted UCC	FY '06 - FY '08 UCC AVERAGE	50/ 50 BLENDED UCC AVERAGE	Revenue Neutrality Adjustment	Current Policy Results	Percent of Gross Patient Revenue that is Charity Care	Charity Care Adjustment	Preliminary Policy Results	Proposed Policy Results
1	2	3	4	5	6	7 = (Col 5 + Col 6)*0.5	8	9 = (Col 7 + Col 8)	10	11 = (Col 10*0.2)	12 = (Col 9 + Col 11)	13
210001	Washington County Hospital	6.67%	7.99%	7.24%	7.51%	7.38%	0.05%	7.42%	3.55%	0.71%	8.13%	7.68%
210002	Univ. of Maryland Medical System	8.69%	9.48%	9.65%	9.67%	9.66%	0.05%	9.71%	3.75%	0.75%	10.46%	9.88%
210003	Prince Georges Hospital	13.35%	14.93%	14.05%	14.22%	14.14%	0.05%	14.19%	0.61%	0.12%	14.31%	13.51%
210004	Holy Cross Hospital of Silver Spring	6.43%	7.37%	6.85%	6.76%	6.80%	0.05%	6.85%	2.46%	0.49%	7.34%	6.94%
210005	Frederick Memorial Hospital	5.62%	5.62%	7.02%	5.59%	6.31%	0.05%	6.35%	1.86%	0.37%	6.73%	6.35%
210006	Harford Memorial Hospital	8.24%	11.95%	8.71%	10.38%	9.55%	0.05%	9.59%	1.40%	0.28%	9.87%	9.32%
210007	St. Josephs Hospital	2.81%	3.36%	3.46%	2.97%	3.22%	0.05%	3.27%	1.06%	0.21%	3.48%	3.28%
210008	Mercy Medical Center, Inc.	7.79%	7.41%	7.56%	7.89%	7.73%	0.05%	7.77%	2.56%	0.51%	8.29%	7.83%
210009	Johns Hopkins Hospital	5.65%	6.08%	6.41%	5.94%	6.18%	0.05%	6.22%	2.25%	0.45%	6.67%	6.30%
210010	Dorchester General Hospital	8.25%	5.97%	9.38%	7.34%	8.36%	0.05%	8.41%	1.06%	0.21%	8.62%	8.14%
210011	St. Agnes Hospital	7.07%	6.24%	7.62%	6.62%	7.12%	0.05%	7.16%	3.53%	0.71%	7.87%	7.43%
210012	Sinai Hospital	7.06%	8.03%	7.13%	7.98%	7.55%	0.05%	7.60%	1.91%	0.38%	7.98%	7.54%
210013	Bon Secours Hospital	13.68%	17.08%	16.33%	15.06%	15.70%	0.05%	15.74%	4.64%	0.93%	16.67%	15.75%
210015	Franklin Square Hospital	7.93%	8.09%	8.75%	8.28%	8.51%	0.05%	8.56%	2.51%	0.50%	9.06%	8.56%
210016	Washington Adventist Hospital	7.29%	9.98%	7.63%	9.48%	8.56%	0.05%	8.60%	2.90%	0.58%	9.18%	8.67%
210017	Garrett County Memorial Hospital	8.08%	9.30%	7.82%	7.50%	7.66%	0.05%	7.71%	5.47%	1.09%	8.80%	8.31%
210018	Montgomery General Hospital	6.03%	5.55%	7.05%	6.30%	6.68%	0.05%	6.72%	3.92%	0.78%	7.51%	7.09%
210019	Peninsula Regional Medical Center	5.56%	6.50%	5.88%	6.25%	6.07%	0.05%	6.11%	2.16%	0.43%	6.54%	6.18%
210022	Suburban Hospital Association,Inc	4.71%	5.04%	5.30%	4.83%	5.07%	0.05%	5.12%	1.55%	0.31%	5.43%	5.12%
210023	Anne Arundel General Hospital	4.36%	4.68%	4.85%	4.59%	4.72%	0.05%	4.77%	1.12%	0.22%	4.99%	4.71%
210024	Union Memorial Hospital	6.33%	6.93%	6.09%	7.13%	6.61%	0.05%	6.66%	2.27%	0.45%	7.11%	6.72%
210025	The Memorial Hospital	4.86%	5.48%	6.09%	5.09%	5.59%	0.05%	5.64%	2.25%	0.45%	6.09%	5.75%
210027	Braddock Hospital	4.06%	4.75%	4.79%	4.61%	4.70%	0.05%	4.75%	2.41%	0.48%	5.23%	4.94%
210028	St. Marys Hospital	6.51%	6.29%	9.69%	5.71%	7.70%	0.05%	7.75%	2.62%	0.52%	8.27%	7.81%
210029	Johns Hopkins Bayview Med. Center	8.68%	9.36%	8.27%	9.37%	8.82%	0.05%	8.87%	5.16%	1.03%	9.90%	9.35%
210030	Chester River Hospital Center	7.39%	11.90%	5.77%	10.68%	8.23%	0.05%	8.28%	2.31%	0.46%	8.74%	8.25%
210032	Union Hospital of Cecil County	7.89%	7.76%	8.88%	7.57%	8.23%	0.05%	8.28%	1.09%	0.22%	8.49%	8.02%
210033	Carroll County General Hospital	5.17%	5.64%	6.87%	4.86%	5.87%	0.05%	5.91%	2.32%	0.46%	6.38%	6.02%
210034	Harbor Hospital Center	9.05%	8.94%	10.57%	9.08%	9.83%	0.05%	9.87%	1.75%	0.35%	10.23%	9.66%
210035	Civista Medical Center	6.10%	7.43%	8.58%	5.88%	7.23%	0.05%	7.28%	0.78%	0.16%	7.43%	7.02%
210037	Memorial Hospital at Easton	5.92%	5.71%	6.62%	5.14%	5.88%	0.05%	5.92%	0.60%	0.12%	6.05%	5.71%
210038	Maryland General Hospital	11.59%	12.71%	13.21%	11.82%	12.51%	0.05%	12.56%	0.78%	0.16%	12.72%	12.01%
210039	Calvert Memorial Hospital	6.14%	5.72%	7.44%	5.74%	6.59%	0.05%	6.64%	1.24%	0.25%	6.89%	6.50%
210040	Northwest Hospital Center, Inc.	7.30%	7.97%	8.17%	7.88%	8.03%	0.05%	8.07%	2.20%	0.44%	8.51%	8.04%
210043	North Arundel General Hospital	6.73%	7.94%	8.08%	7.48%	7.78%	0.05%	7.83%	1.33%	0.27%	8.10%	7.65%
210044	Greater Baltimore Medical Center	2.54%	2.81%	4.03%	2.69%	3.36%	0.05%	3.41%	0.39%	0.08%	3.49%	3.29%
210045	McCready Foundation, Inc.	6.84%	10.27%	9.66%	8.10%	8.88%	0.05%	8.93%	3.39%	0.68%	9.61%	9.07%
210048	Howard County General Hospital	5.73%	5.21%	7.09%	5.25%	6.17%	0.05%	6.22%	0.66%	0.13%	6.35%	5.99%
210049	Upper Chesepeake Medical Center	5.47%	5.90%	6.60%	5.57%	6.09%	0.05%	6.14%	1.00%	0.20%	6.34%	5.98%
210051	Doctors Community Hospital	8.25%	10.88%	9.99%	9.61%	9.80%	0.05%	9.84%	0.43%	0.09%	9.93%	9.38%
210054	Southern Maryland Hospital	7.39%	9.49%	8.23%	8.61%	8.42%	0.05%	8.47%	0.68%	0.14%	8.60%	8.12%
210055	Laurel Regional Hospital	11.07%	12.63%	10.69%	11.76%	11.22%	0.05%	11.27%	0.28%	0.06%	11.33%	10.70%
210056	Good Samaritan Hospital	5.72%	5.80%	5.97%	5.90%	5.93%	0.05%	5.98%	1.41%	0.28%	6.26%	5.91%
210057	Shady Grove Adventist Hospital	6.60%	6.66%	7.97%	7.18%	7.58%	0.05%	7.63%	2.84%	0.57%	8.19%	7.74%
210058	James Lawrence Kernan Hospital	6.30%	6.22%	2.37%	6.58%	6.58%	0.00%	6.58%	0.50%	0.10%	6.68%	6.31%
210060	Fort Washington Medical Center	9.60%	14.20%	10.17%	13.30%	11.74%	0.05%	11.78%	1.40%	0.28%	12.06%	11.39%
210061	Atlantic General Hospital	5.64%	5.48%	6.27%	5.58%	5.93%	0.05%	5.97%	1.36%	0.27%	6.25%	5.90%
	STATE-WIDE	6.74%	7.39%	7.45%	7.21%	7.35%	0.05%	7.39%	2.17%	0.43%	7.83%	7.39%

Appendix

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

October 1, 2009

Sent via e-mail. ***Hard copy to follow***.

Nduka Udom
Associate Director, Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Udom:

On behalf of the 67 members of The Maryland Hospital Association (MHA), I appreciate the opportunity to comment on the HSCRC's *Draft Recommendation on Handling Charity Care in the Uncompensated Care Provision*.

MHA supports the HSCRC staff proposal that would create an incentive for Maryland hospitals to provide more charity care, and to appropriately report to the commission just how much charity care they provide. Also, MHA supports the methodology utilized to adjust the uncompensated provision, as outlined in Tables 1 and 2 of the draft.

MHA, however, opposes the use of FY 2009 data in the new policy adjustment. The 2009 fiscal year is ended and accounting records will be closed within a few weeks. An incentive to emphasize and differentiate charity care from uncompensated care should be prospective in nature and begin with FY 2010.

MHA requests that HSCRC staff develops reporting instructions and definitions on what is to be reported as charity care for the HSCRC rate-setting purposes. We recommend that the HSCRC review this data in their annual special audit procedures before the adjustment to the uncompensated care provision is implemented. Also, this data should be reconciled to the HSCRC Community Benefits data and to hospital's IRS 990 Form.

In conclusion, we are supportive of the proposed uncompensated provision change, but recommend that implementation is delayed until FY 2010 data is available.

Thank you for your time and attention to this matter. Furthermore, MHA will be happy to assist you in developing the definitions and reporting instructions. Should you have any questions, please contact me at 410-379-6200.

Sincerely,

Robert Z. Vovak
Senior Vice President and CFO

Hal Cohen, Inc.
Health Care Consulting
17 Warren Road, 13B
Baltimore, Maryland 21208
(410) 602-1696; Fax: (410) 602-1678: e-mail: JandHCohen@AOL.com

September 22, 2009

Nduka Udom Via e-mail

Dear Andy:

This letter, written on behalf of CareFirst BlueCross BlueShield and Kaiser Permanente, offers our comments on the proposal entitled "Draft Recommendation on Handling Charity Care in the Uncompensated Care Provision" as distributed at the September 2, 2009 Commission meeting.

CareFirst and Kaiser Permanente support the idea behind the staff proposal that charity care is preferable to bad debts for patients who cannot afford to pay their hospital bills. The idea of an adjustment that is revenue neutral but shifts money toward hospitals that provide a larger share of their uncompensated care (UCC) via charity care makes sense. We understand that this policy is revenue neutral in the static sense, but that if it tends to increase UCC over time, then it is not revenue neutral. Nevertheless, we support the idea.

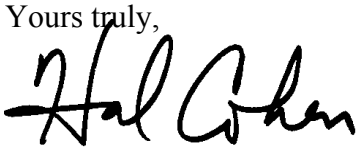
The only question we have is whether the hospital UCC data that will be submitted for 2009 should form the basis of full application of the methodology in 2011. We know that hospitals have been on notice to provide accurate data on the split of charity care and bad debts, but the data suggest that several hospitals did not do so during 2008 and, since the books for three quarters of FY 2009 were closed for most hospitals when this policy was proposed, we expect that several hospitals will provide bad data for 2009 as well – where the primary error in the data is to underreport charity care relative to bad debts.

As a result, we recommend that the policy not be put in place 100% in 2011 as proposed. To make sure this policy begins, we suggest that the new methodology be given either a 25% or 50% weight in 2011 and then applied 100% in 2012. An alternative modification would be to apply the policy 100% to hospitals that gain and 25% to hospitals that lose and then apply the revenue neutral adjustment.

The important point is that, as Commissioner Sexton said at the last meeting, from a patient's perspective, charity care is much preferable to bad debts. CareFirst and Kaiser Permanente support the adoption by the HSCRC of a policy that reflects that perspective.

Thank you for your consideration.

Yours truly,



Hal Cohen
Consultant

Cc: Robert Murray
Steve Ports
Am anda Greene
John Hamper
Debra Collins
Jessica Boutin

UNIVERSITY OF MARYLAND
MEDICAL SYSTEM
110 S. Paca Street – 7th Floor
Baltimore, Maryland 21201

October 2, 2009

Mr. Nduka Udom
Associate Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Udom:

The purpose of this letter is to comment on the staff's "Draft Recommendation on Handling Charity Care in the Uncompensated Care Provision," presented at the September 2, 2009 Commission meeting. In this recommendation, the staff describes changes to the current uncompensated care methodology. These changes are designed to encourage the use of charity care in Maryland hospitals for qualified patients. The document proposes to modify the current methodology by first adding 20 percent of each hospital's current level of charity care as a percent of gross patient revenue to the hospital's current policy result and then applying a revenue neutrality adjustment.

While the staff's recommendation is an admirable attempt to reward hospitals with large charity care provisions, the boost to these hospitals is in fact relatively small. The numbers in Table 1 of the staff recommendation show relatively minor adjustments for hospitals with large shares of charity care. If the goal of the policy is to encourage charity care to qualified patients, the policy should contain stronger, clearer provisions that reward hospitals for charity care. Additionally, while the policy does provide more uncompensated care in rates, the mechanics of the process are not clear. For example, why is 20 percent of charity care included and not a different number? Is a larger share justified? If so, what are the effects on uncompensated care that are not part of the charity care provision? These issues merit further discussion before this policy is adopted.

Furthermore, we would advocate a more straightforward and transparent method for modifying the current policy. A possible alternative might be to separate the bad debt provision from charity care. The current methodology, or a reasonable modification, could be used for calculating the amount of bad debt in rates while charity care could be recognized separately.

Finally, each model should be evaluated for its stability over time. In the most recent modifications to the uncompensated care policy, this approach has proven useful for assessing changes to the policy, and such an evaluation would prove useful for this proposal as well.

The draft recommendation calls for the new policy to begin in FY2011, based on FY2009 data. We request that any changes to the uncompensated care policy based on charity care provisions take effect in FY2012 based on FY2010 data. While hospitals are obligated to report accurately whether the data elements are used in the uncompensated care provision or not, the reality is that hospitals review reported data differently when these elements are used in policy calculations. With competing demands for data

and reporting, higher priority is given to data elements that directly affect hospital rates. Because the charity care provision has not been used before, there is likely to be substantial variability in the quality of the reported data. Because each hospital's rate depends on its own reported data and the data of other hospitals in the State, accurate reporting is essential for establishing reasonable levels of uncompensated care based on the charity care provision. The rates will be more accurate and stable if hospitals have time to pay increased attention to charity care reporting.

We request that the current staff proposal not be adopted as policy at this time and that the policy be given further consideration. While the proposal addresses essential elements for incorporating incentives for more charity care, alternative approaches have not been discussed in detail. We believe more direct and transparent alternatives are possible. Because the staff proposal would not take effect until July 1, 2010, further consideration of alternatives would not delay the staff's rate-setting activities.

We appreciate your consideration in this matter. Please contact me if you have any questions.

Sincerely,

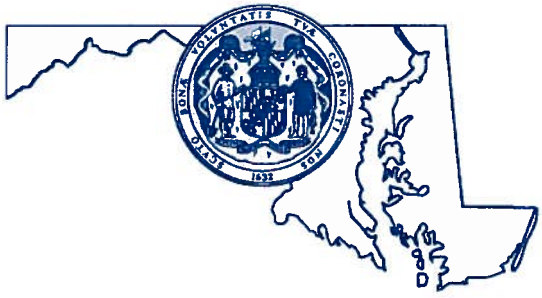
Alicia Cunningham

Alicia Cunningham
Vice President
Reimbursement & Revenue Advisory Services

AC/lfn

cc: Hank Franey

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE



HEALTH SERVICES COST REVIEW COMMISSION
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October 1, 2009

The Honorable Martin O'Malley
State House, 100 State Circle
Annapolis, MD 21401

The Honorable Thomas V. Mike Miller, Jr.
H-107, State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
H-107, State House
Annapolis, MD 21401-1991

Subject: Report on Sections 2 and 3 of Chapters 310 and 311 of 2009 Laws of Maryland

Dear Governor O'Malley, President Miller, and Speaker Busch;

Chapters 310 and 311 of the 2009 Laws of Maryland require the Health Services Cost Review Commission ("Commission," or "HSCRC") to establish a Work Group to consider issues regarding patient financial assistance and debt collection. Attached please find the report of the HSCRC Work Group on Financial Assistance and Debt Collection.

Specifically, Chapters 310 and 311 require the Commission to report to the Governor and the General Assembly by Oct. 1, 2009 on the need for uniform policies among hospitals relating to patient financial assistance and debt collection and consider uniform policies for:

- Income thresholds and any special treatment of disability and pension income;
- Asset thresholds and treatment of various types of assets;
- Use of liens to enforce collection of debt;
- Collection procedures;
- Establishment of guardianship;
- Use of judgments to collect debts; and
- Patient education and outreach to inform patients of financial assistance policies.

The Work Group was also charged with reviewing whether uniform policies should apply to psychiatric and chronic hospitals, and whether the legal rate of interest on a judgment to collect a hospital debt should be changed. Separate from the Work Group, the Commission was required to study the creation of incentives for hospitals to provide free or reduced-cost care to patients without the means to pay their bills and report their findings to the General Assembly. This report fulfills the legislative reporting requirements of both Section 2 (financial assistance and debt collection) and Section 3 (HSCRC uncompensated care policy incentives) of Chapters 310 and 311 of the 2009 Laws of Maryland.

The Work Group met six times over the past several months and discussed the various issues set out in the legislation. The Work Group considered legislation in other states that have been proactive on financial assistance and collection issues as well as the guidelines and policies of major stakeholder organizations. The report proposes a series of recommendations relative to financial assistance policies, presumptive eligibility, reduced cost care, medical hardship, how assets should be treated, documentation requirements, patient responsibilities, patient education and outreach, collection policies, reporting requirements, treatment of psychiatric and chronic care hospitals, and creating incentives for charity care in the HSCRC's uncompensated care policy. The recommendations embodied herein will require a combination of legislative, regulatory, and guideline changes. The report and recommendations have been reviewed by the Commission.

The Commission sincerely thanks the members of the Work Group for sharing their expertise and providing input on these matters in a short period of time. The Commission also thanks the Hilltop Institute and Verite Consulting for their research and guidance through this process.

Thank you for the opportunity to submit findings on these issues, and we look forward to working with you and the various stakeholders to implement the provisions of the report.

Sincerely,

Robert Murray
Executive Director

cc: The Honorable Thomas Middleton
The Honorable Rob Garagiola
The Honorable Peter Hammen
Marie Grant (Senate Finance Committee)
Linda Stahr (House Government and Operations Committee)

Report to the Governor and General Assembly Pursuant to Sections 2 and 3 of Chapters 310 and 311 of the 2009 Laws of Maryland:

HSCRC Work Group Review of the Need for Uniform Policies among Maryland Hospitals on Patient Financial Assistance and Debt Collection

Maryland Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, Maryland 21215

October 1, 2009

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Report to the Governor and General Assembly Pursuant to Sections 2 and 3 of Chapters 310 and 311 of the 2009 Laws of Maryland: HSCRC Work Group Review of the Need for Uniform Policies among Maryland Hospitals on Patient Financial Assistance and Debt Collection

Executive Summary

Chapters 310 and 311 of the 2009 Laws of Maryland require the Health Services Cost Review Commission ("Commission," or "HSCRC") to establish a Work Group to consider outstanding issues regarding patient financial assistance and debt collection. Specifically, these provisions require the Commission to receive input from the Work Group and report to the Governor and the General Assembly by October 1, 2009 regarding the need for uniform policies among Maryland hospitals relating to patient financial assistance and debt collection; including for:

- Income thresholds and any special treatment of disability and pension income;
- Asset thresholds and treatment of various types of assets;
- Use of liens to enforce collection of debt;
- Collection procedures;
- Establishment of guardianship;
- Use of judgments to collect debts; and
- Patient education and outreach to inform patients of financial assistance policies.

The Work Group is also charged with reviewing whether the legal rate of interest on a judgment to collect a hospital debt should be altered and whether uniform policies should apply to psychiatric and chronic hospitals.

Separate from the Work Group, the Commission is required to study the creation of incentives for hospitals to provide free or reduced-cost care to patients without the means to pay their bills and report its findings to the General Assembly.

The Commission selected Work Group members who would represent several key stakeholder groups, including hospitals, public and private payers, legal aid and consumer rights organizations, business owners, and local public health officers. Moreover, the Commission solicited and utilized comments from the public at each meeting, including credit and collection firms. The Work Group was actively attended and took its responsibilities seriously, and the final set of recommendations incorporates input from all Work Group members. The Work Group began meeting in July of 2009 and conducted six meetings addressing the issues detailed in Chapters 310 and 311. The deliberations of the Work Group during these meetings and the Commission's review of financial assistance and collection policies in Maryland, the methodologies whereby hospitals recover charity care and bad debt via the rate setting system, and how other states have approached these matters, indicate that there is a need to create certain minimum standards. However, the review also indicates that any such standards should not preclude some degree of flexibility for both the HSCRC and for hospitals in the establishment and implementation of policy alternatives. Flexibility

will allow for policies that reflect the different characteristics of communities, patients, and hospital service areas across Maryland and allows hospitals to provide financial assistance and payment plans to uninsured and underinsured patients most in need. Maryland hospitals also note that attempting to collect the full amount from patients who are unable to pay their bills is costly to the hospital and to those patients.

The culmination of Work Group deliberations and the results of the Commission's February 2009 review have revealed that voluntary policies of Maryland hospitals as well as requirements set forth in State law and regulation have placed Maryland among the most progressive states in dealing with issues of financial assistance and debt collection. Still, HSCRC surveys and HSCRC's February 2009 comprehensive review of financial assistance policies in Maryland also indicate that variation exists in policies and procedures, and instances occur where patients can "fall through the cracks". Establishing statewide, uniform, mandatory, minimum standards for patient financial assistance and medical debt is warranted.

The HSCRC believes that the recommendations contai ned in this report both protect uninsured and underinsured patients from being saddled with hosp ital bills they are unable to pay, while at the same tim e, allowing f lexibility f or hospita ls to c ontinue to provide assist ance to pa tients in wa ys they individually deem to be appropriate.

The recommendations that follow in this report are intended to be a comprehensive, integrated, holistic approach to this issue. Accordingly, modifying or eliminating any one recommendation may suggest the need to modify or add others. The recommendations specifically are not intended to be an ala carte menu, where some may be selected and others omitted; doing so would disrupt and undermine the integrity of the package as a whole.

The HSCRC would like to thank th e participants in the Work Gr oup discussions for addressing many pertinent issues in a short pe riod tim e. Al l parties provided inform ed input which helped to shape these recommendations. Below is a summary of the recommendations, which is elaborated in Section V of this report:

I. Financial Assistance Policies
    a. Free care should be available to patients in households between 0% and 200% of FPL but hospitals demonstrating hardship may request a threshold no lower than 150% of FPL.
    b. Reduced-cost care should be available to uninsured patients between 200% and 300% of FPL, but hospitals demonstrating hardship may request lower thresholds.
    c. The maximum payment for reduced-cost care should not exceed the charges minus the Commission's aggregate markup.
    d. If a patient is later found to be eligible for free care on the date of service, hospitals should refund any collections received over a specified amount under certain circumstances.

e. Patients already enrolled in certain means-tested programs are deemed to be eligible for free care on a presumptive basis.

II. Medical Hardship
   a. Medical debt for certain uninsured and underinsured patients incurred over a 12-month period should not exceed 25% of the patient's household income.
   b. Hospitals may exclude patients from medical hardship provisions if their household income exceeds 500% of FPL.
   c. If a patient is eligible for both reduced cost care and medical hardship, the hospital should employ the more generous policy to the patient.

III. Assets
   a. Hospitals may choose monetary assets in addition to income-based criteria, but the asset test must adhere to certain criteria.
   b. Criteria should include those assets convertible to cash, excluding up to $150,000 in a primary residence, and certain retirement benefits where the IRS has granted preferential treatment.
   c. At a minimum, the first $10,000 in monetary assets should be excluded.

IV. Documentation Requirements
   a. Hospitals may require of patients only those documents necessary to validate information on the Maryland State Uniform Financial Assistance Application.
   b. These documents would not be required for patients deemed eligible for free care on a presumptive basis.

V. Patient Responsibilities
   a. Hospital information sheets should inform patients of their responsibility to pay hospital bills in good faith and to provide relevant information to determine eligibility for financial assistance or payment options with 30 days of the hospital's request for information.
   b. Hospitals should inform patients that they may be required to first apply for eligibility for public programs prior to determining eligibility for financial assistance.

VI. Patient Education and Outreach
   a. Existing law regarding the posting of notices of the availability of financial assistance policies should include inpatient and outpatient admitting and registration areas and the emergency room.
   b. Posted notices should be reasonably legible and of a certain size and in certain languages.
   c. As part of the financial counseling process, hospitals should provide interpreter services in certain languages and the information sheet should be available in certain languages.

VII. Collection Policies
   a. Hospitals should provide, upon request, an estimate of charges for hospital services, procedures or supplies in advance of the visit.

b. Hospitals should provide patients with information on how to contact the hospital to inquire about or dispute bills.
c. Hospitals should not report a patient to a credit reporting agency until 120 days after the first initial bill except under certain circumstances.
d. Hospital board-approved credit and collection policies should include procedures for when debts may be reported to credit reporting agencies, when legal action may commence, when garnishments may be applied, and when a lien may be placed.
e. If a hospital delegates collection activity to a collection agency, it should do so pursuant to a contract that requires the agency to abide by the hospital's policies.
f. Patients should be able to file grievances to hospitals regarding the activities of their collection agents.
g. Hospitals and their agents should remove any patient debt items from credit reports when a bill is paid in full.
h. No change is recommended to the current pre-judgment or post-judgment laws and regulations.
i. Hospitals should not permit the forced sale or foreclosure of a patient's primary residence to collect an outstanding medical debt.

VIII. Miscellaneous Policies

a. Financial assistance and credit and collection policies should be reviewed and approved by the hospital's Board of Directors at least every 3 years.
b. Hospitals should offer interest-free payment plans to uninsured patients with income between 200 and 500% of FPL that request assistance.
c. Hospitals should provide the ability for patients to have financial assistance decisions reconsidered.
d. The Work Group supports refinement and proliferation of One-e-App on a statewide basis.

IX. Reporting Requirements

a. Hospitals should include in their existing reports on financial assistance and collection polices to the HSCRC information regarding:
    1. Their collection agencies; and
    2. The number of liens placed on residences, extended payment plans beyond 5 years, and documentation required of individuals to qualify for financial assistance
b. Hospitals should also report to the HSCRC whether they report to their Boards of Directors regarding the number of accounts:
    1. reported to credit reporting agencies;
    2. where wage garnishments were imposed;
    3. where liens were placed on residences or motor vehicles; and
    4. where legal action was taken.

X. Special Treatment of Private Psychiatric and Chronic Care Hospitals

a. The recommendations of the report should apply to chronic care hospitals;

b. Application of these recommendations to private psychiatric hospitals should be deferred at this time.

XI. Establishing Incentives for Charity Care in the HSCRC Uncompensated Care Policy

a. The Commission should alter its uncompensated care policy by providing additional incentives for hospitals to maximize the use of charity care.

The following guiding principles were used by the HSCRC and the Workgroup as criteria/rationales in arriving at these recommendations:

- Maryland hospitals support access to medically necessary care for all patients, regardless of financial means.
- Maryland's unique rate-setting system provides hospitals with protection for the provision of virtually all uncompensated care.
- Financial Assistance (charity care) is more appropriate than bad debt (and its associated collections processes) for patients who cannot afford their hospital bills. While the financial impact of write-offs on hospitals currently is the same, financial assistance is less stressful on patients and it avoids administrative procedures that can ultimately prove unfruitful.
- Some level of uniformity in financial assistance and collection policies is appropriate to create a statewide floor.
- Some measure of flexibility in these policies is necessary to reflect varying socioeconomic differences in the hospitals' service areas and patient mix.
- The potential impact on a hospital's financial condition must be considered.
- Fairness to patients, purchasers, and payers of hospital care is the objective.
- The administrative burden associated with the policies must be manageable (for hospitals, patients, HSCRC, and other parties).
- Maryland has been among the most progressive states in adopting laws, regulations, and voluntary guidelines relating to hospital financial assistance and collection policies. Maryland should continue to innovate in this area.
- Accountability on the part of the hospital in balancing the needs of patients with hospital financial factors, as well as on the part of patients to provide adequate documentation in a timely manner is required.

This report and the recommendations contained herein have been reviewed by the Commission.

Report of HSCRC Work Group on Patient Financial Assistance and Hospital Debt Collection

I. Introduction

In December 2008, Governor Martin O'Malley requested a thorough review of the credit and collection practices of Maryland's hospitals. Specifically, the Governor asked that the Health Services Cost Review Commission ("Commission" or "HSCRC") evaluate these issues and, at a minimum, address the extent to which those policies differ across hospitals; whether hospitals have become more aggressive over time; and whether regulatory or legislative changes are required.

The Commission, in turn, conducted a review of hospital financial assistance policies, credit and collection policies and activities, and the Commission's uncompensated care methodology and policies. In February of 2009, the Commission issued a detailed report suggesting both legislative and administrative changes that attempt to address some of the Governor's concerns. Following the submission of that report, the Commission pursued audit activities designed to determine how consistently hospitals are following their financial assistance and collection policies and Generally Accepted Accounting Principles with regard to Bad Debt recoveries. HSCRC staff also recommended establishing additional incentives for hospitals to provide free care to eligible patients.

As a result of the findings of that report, legislation passed during the 2009 Session of the Maryland General Assembly. That legislation set certain minimum standards regarding the income threshold for free hospital care, and established some requirements for hospital financial assistance, collection policies and consumer information sheets. Chapters 310 and 311 (Senate Bill 776 and House Bill 1069), which can be found in Appendix I, made changes to state law in the following areas:

Financial Assistance Policy

Chapters 310 and 311 provide that the Commission shall require acute care hospitals in Maryland to develop financial assistance policies for providing free and reduced care to patients who lack coverage or whose coverage does not pay the full costs of the hospital bill. At a minimum, a hospital's policy would provide that patients whose income is at or below 150% of the federal poverty level (FPL) would be eligible for free care. The policy for reduced-cost care to low-income patients would be dependent on the hospital's mission and the hospital's service area. The Commission may establish higher thresholds but must take into account a hospital's patient mix, financial condition, level of bad debt, and level of charity care.

The Commission has promulgated regulations, and the 150% free care provision became effective beginning June 19, 2009. The regulations also state that hospitals that had more generous policies prior to the promulgation of the regulations should at least maintain their current free care threshold.

Information Sheet

Under that legislation, each hospital is required to develop an information sheet to be provided to patients and their representatives (at discharge, with hospital bills, and on request) that:

- Describes the financial assistance policy;
- Describes the patients' rights and obligations regarding billing and collection under the law;
- Provides contact information to assist the patient and family in understanding the bill, the patient's rights and obligation, how to apply for free or reduced-cost care, and how to apply for Medicaid;
- Provides Medicaid contact information; and
- Clarifies that physician charges are billed separately.

After convening an Information Sheet Work Group, the Commission issued guidelines to hospitals in developing their information sheets and required all hospitals to submit their information sheets to the Commission by mid-June. After reviewing the information sheets, Commission staff will further refine the information sheet guidelines to ensure that they are effective in informing patients of their ability to apply for financial assistance and how to begin the process. A copy of the current guidelines can be found in Appendix II.

Availability of Hospital Staff to Assist Patients

Chapters 310 and 311 require hospitals to provide trained staff to work with patients and their representatives on understanding their bill, their rights and obligations, how to apply for Medicaid, and how to contact the hospital for additional assistance.

Policy on Collection of Debts

The legislation provides that each hospital is required to submit to the Commission (at times prescribed by the Commission) its policy on the collection of debts.

The Policy shall:

- Provide active oversight of the contracts with third parties to collect debts on the hospital's behalf;
- Prohibit the hospital from selling any debt;
- Prohibit charging prejudgment interest on self-pay (uninsured) patients;
- Describe the hospital's income and asset criteria for granting assistance;
- Describe the hospital's collection procedures for collecting debt;
- Describe those circumstances where a hospital may seek judgment.

The Commission was charged by the legislation to review each hospital's implementation of, and compliance with, the collection policies and issue a report.

Fines

Chapters 310 and 311 also permit the Commission to impose fines not to exceed $50,000 per violation if a hospital knowingly violates the financial assistance or collection policy provisions in the bill.

Reports to the Governor and General Assembly

Finally, the Commission was to establish a Work Group to consider outstanding issues regarding patient financial assistance and debt collection. Specifically, it requires the Commission to report to the Governor and the General Assembly by Oct. 1, 2009 on the need for uniform policies among hospitals relating to patient financial assistance and debt collection, and consider uniform policies for:

- Income thresholds and any special treatment of disability and pension income;
- Asset thresholds and treatment of various types of assets;
- Use of liens to enforce collection of debt;
- Collection procedures;
- Establishment of guardianship;
- Use of judgments to collect debts; and
- Patient education and outreach to inform patients of financial assistance policies.

The workgroup was also charged with reviewing whether uniform policies should apply to psychiatric and chronic hospitals, and the desirability of altering the legal rate of interest on a judgment to collect a hospital debt.

Separate from the Work Group, the Commission was required to study the creation of additional incentives for hospitals to provide free or reduced-cost care to patients without the means to pay their bills, and report their findings to the General Assembly.

Financial Assistance and Debt Collection Work Group

During the spring of 2009, the Commission began to solicit participants from various stakeholders in an effort to establish the work group. During this process, it became evident that there were few organized stakeholder groups in Maryland that represent patients in need of financial assistance. The Commission made an effort to establish a balanced work group but found it difficult to do so. Ultimately, the Commission selected Work Group members who would represent several key stakeholder groups, including hospitals, public and private payers, legal aid and consumer rights organizations, business owners, and local public health officers. The Commission supplemented the Work Group by actively soliciting and utilizing public comments, and found comments from a representative of the credit and collection industry to be very helpful. The Work Group actively attended and participated in the six meetings, and took its responsibilities seriously. Still, the general absence of other organized stakeholders on the issues at hand meant that hospital representatives comprised the majority of the Work Group membership and dominated much of the

deliberations. A roster of the Work Group members and their affiliations can be found in Appendix III. The groups include:

- The MHA and Maryland Hospital Representatives
- Legal Aid Bureau
- Local Health Departments
- Private Payers
- Medicaid; and
- Maryland Chamber of Commerce

Representatives from third party collection agencies attended all meetings and provided comments and input during each meeting.

The Commission also procured the services of the Hilltop Institute to provide technical assistance in reviewing actions taken in other states and recommended by national associations and stakeholder groups regarding financial assistance and debt collection policies, summarizing Maryland's hospitals current policies, and assisting with research. The Hilltop Institute, located at University of Maryland – Baltimore County, is a nationally recognized research center dedicated to improving the health and social outcomes of vulnerable populations. Hilltop conducts research analysis and evaluation on behalf of government agencies, foundations and other non-profit organizations at the national, state and local levels. Joining Hilltop was Verité Healthcare Consulting, LLC which has unique national experience in consulting on issues of community benefits, including best practices for financial assistance policies for uninsured and underinsured consumers.

The Work Group met six times between July and September of 2009. The agenda and minutes for each meeting can be found on the HSCRC website (www.hscrc.state.md.us). The recommendation section of this report also presents the Commission's progress in implementing incentives in its uncompensated care methodology for hospitals to maximize the use of charity care. Therefore, this submission fulfills both reporting requirements (hospital financial assistance and collection policies, and incentives in HSCRC uncompensated care policy) under Chapters 310 and 311.

While an individual Work Group member might disagree with a specific recommendation contained here, the recommendations as a whole reflect the opinions of the Commission and the Work Group. Work Group members were given the opportunity to submit a letter with their individual comments; those letters may be found at Appendix VIII.

The report and recommendations that follow represent an attempt at crafting the most balanced set of policies and requirements. The recommendations were crafted to reflect hospital financial assistance and credit and collection policies and requirements from the most progressive states and the deliberations of the Work Group. As such, the HSCRC staff believes if implemented, they will be in the best interest of the public broadly defined.

The report and the recommendations have been reviewed by the HSCRC Commissioners.

II. Background

Nationally

The continued deterioration of the economy both nationally and in Maryland has raised the specter of health care financial assistance and collection in recent years. The combination of increased unemployment, reduced governmental assistance, and continued increases in health care costs have exacerbated the upward trend in the number of uninsured and underinsured people. Absent universal health care coverage for US citizens, these trends are expected to continue to rise.

Before Maryland's legislative action in 2009, several states had already initiated legislation, regulations, or voluntary agreements or recommendations with hospitals to establish minimum standards for hospital financial assistance and require stricter standards for hospital billing practices, notably California, Connecticut, Illinois, Ohio, Minnesota, Missouri, Massachusetts, New York, and New Jersey. Very recently, new research on the growing problem of medical bankruptcy and medical debt has raised awareness about the serious consequences such liabilities place on households, even for the insured. Federal health reform legislation proposed in September 2009 includes charity care and collections provisions that hospitals would be required to meet to qualify for federal tax exemption under 501(c)(3) of the Internal Revenue Code.

These issues were illustrated in a June 2009 article in the *American Journal of Medicine* which found that over 60 percent of all bankruptcies in 2007 were driven by medical incidents. Approximately three-quarters of those people reporting a medical bankruptcy had insurance at the time they became sick or injured. About 35 percent of medically bankrupt persons spent more than $5,000 or more than 10 percent of their annual income on out-of-pocket medical bills. The uninsured incur medical debt at a far higher rate than the insured[1].

Other studies have shown that people with low incomes are more likely to report problems paying medical bills. These problems almost universally lead to at least one significant financial burden, including problems paying for essentials like food and housing, contemplating bankruptcy, trouble with collection agencies, or putting off major purchases. About 27 percent of adults with incomes less than 300 percent of the FPL report medical bill problems, with an average out-of-pocket expense of $1,080. Calculated as a percentage of family income, this average spending amount is equivalent to 5.3 percent of income[2].

Even small medical bills can be yield financial problems for households. About 40 percent of people reporting medical bill problems have had out-of-pocket expenses of $500 or less in the previous year. Financial pressures on families from these bill problems increase sharply when out-

[1] Himmelstein, Thorne, Warren, & Woolhander, 2009 David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhander, Medical Bankruptcy in the United States, 2007: Results of a National Study, The American Journal of Medicine, June 2009

[2] Cunningham, Miller, & Cassil, 2008 – Living on the Edge – Health Care Expenses Strain Family Budgets, Research Brief #10, December 2008,

of-pocket spending for health care exceeds 2.5 percent of family income. At 200 percent of the FPL for a family of two, this 2.5 percent threshold is equivalent to $729 (based on the 2009 guidelines)[3].

Nationally, medical bill problems can result from specific episodes of treatment not covered by insurance (including Medicare), but can also result from the accumulation of regular, ongoing out-of-pocket medical expenses for people with chronic conditions, including the insured. People in fair or poor health and people with chronic conditions are more likely to report problems paying medical bills for out-of-pocket spending below 2.5 percent of income and at all levels of out-of-pocket spending[4].

Maryland

Patients and hospitals in Maryland encounter many of the same issues; however, the existence of the All-Payer System in Maryland, which provides financing for charity care services, invokes a different set of challenges and opportunities. Maryland is unique in that it is the only state to retain an All-Payer hospital rate setting system. This system is made possible by a federal waiver (the "Medicare Waiver") from the national hospital reimbursement principles of Medicare and Medicaid. The State law mandating that non-governmental payers pay on the basis of HSCRC-approved rates (in conjunction with the Medicare Waiver) has enabled the State to continuously operate its "All-Payer" system the past 31-plus years. This unique system provides the State with some significant advantages in approaching the issue of financial assistance and medical debt collection policies, and how changes to such policies may be financed.

One of the primary goals of the All-Payer system is to ensure financial access to care for all Maryland citizens. Indeed, the development of a fair mechanism to pay for hospital uncompensated care was a primary reason Maryland's hospitals supported the creation of rate regulation in the State in 1971.

Commensurate with this goal of access is the desire on the part of the State to support hospitals' social mission. The legislature believed that public service, including the provision of medical care to the indigent, was an essential public duty of the hospital industry. Hospitals serve patients for medically necessary or emergent services without regard to their ability to pay, and the financing of UC costs is treated as a responsibility to be shouldered by all payers. Hospitals are compensated for reasonable amounts of uncompensated care delivered through this equitable payment structure.

In carrying out this social mission, however, hospitals have an obligation to be efficient and effective in their operations. This responsibility is in keeping with the Commission's principal regulatory responsibility – to establish rates that permit efficient and effective operation. Finally, the Commission has the responsibility to make hospitals accountable for all areas of their operations, including their commitments to their communities – e.g., reasonable debt collection activities.

[3] Cunningham, Miller, & Cassil, 2008
[4] Cunningham, Miller, & Cassil, 2008

There are inherent tensions between the goal of providing financial access to care for all Maryland citizens and simultaneously holding hospitals to be as efficient and effective as they can be in their collection practices. Hospitals, in particular those that are exempt from local, state, and federal taxation, must maintain their mission to serve while actively pursuing payment from those patients who are able to pay. It is not always clear how best to balance these somewhat conflicting goals, particularly when the billing and collection process can be complex. What is clear, however, is that patients, hospitals, and the HSCRC should all share the responsibility for achieving the most appropriate balance.

III. Trends in Financial Assistance and Collection Policies in Maryland

Maryland has been among the most progressive states in implementing legislative, regulatory and voluntary provisions for financial assistance and collection policies. Some of the legislative changes in this area can be found in House Bill 627, which was enacted during the 2005 Legislative Session and which required hospitals to develop their own financial assistance policies and submit their policies to the Commission on the collection of debts owed by patients who qualify for reduced-cost care under their financial assistance policies. The Commission issued a collection policy survey in 2006 and updated that survey in December 2008. There was little difference in the responses from 2006 and 2008. In response to the Governor's request to review the status of financial assistance policies in Maryland, the 2008 survey added questions regarding various elements of hospitals' financial assistance policies. Appendix IV shows the results of the surveys, and below is a summary of these findings. It is important to note that this survey was issued prior to the passage of Chapters 310 and 311. While Maryland hospitals and the regulatory and legislative requirements have been proactive, the Commission's February 2009 report to the Governor illustrated that there is much variation among hospitals regarding these policies. Findings from that report are summarized below.

Income Policies

At the time of the 2009 survey, MHA had in place voluntary guidelines suggesting hospitals use, as a minimum, 150% of the FPL as the threshold for free care. The analysis found that the vast majority of hospitals met this standard. Fifteen hospitals used precisely this standard, and 23 hospitals had a higher threshold, ranging from 175 to 300 percent of the FPL (the most common figure among this group is 200 percent of the FPL). A few hospitals (five) did not state a specific income level; they addressed patient eligibility for free care on a case-by-case basis. A review of the submitted financial assistance policies showed that four hospitals failed to meet MHA's voluntary guideline for free care. Three hospitals use a free care threshold as low as 100 percent of the FPL.

With these few exceptions, Maryland's hospitals generally fell between 150 and 200 percent of the FPL in establishing eligibility for free care. For the reduced-cost care threshold, MHA's voluntary guidelines utilize the figure of 200 percent of the FPL. In our analysis, we found that 7 hospitals used the MHA guideline; 20 hospitals use a percentage higher than the MHA guideline (ranging from 230 percent to 400 percent); and 5 set the upper limit not based on an FPL, but rather based on

the patient's "ability to pay." Twenty-seven hospitals also have a policy on "catastrophic" expenses for patients deemed "medically indigent," meaning these hospitals provide financial assistance at income levels above their ordinary standards when the size of the hospital bill is so large that it creates financial hardship for persons even with comparatively high household income.

Asset Test

The MHA voluntary guidelines state that a patient should have less than $10,000 in "net assets" in order to qualify for financial assistance. Twelve hospitals used that guideline, but the verbiage may be "assets" or "liquid assets" rather than "net assets." Four hospitals set a lower limit and 19 set a higher limit. Nineteen hospitals' policies were silent on how assets are to be considered when qualifying patients for financial assistance. Some hospitals' policies excluded the patient's primary residence and a first car from inclusion in the asset test, while most policies did not address exclusions. There was no prevailing "center of gravity" for how Maryland hospitals consider assets in order to make financial assistance determinations.

Conversion to Bad Debt

The February 2009 study indicated that almost all Maryland hospitals require self-pay patients to pay a deposit on admission and to pay the balance of the bill on discharge, or enter into an extended payment agreement acceptable to the hospital.

Maryland hospitals most frequently convert a debt into a bad debt when the obligation is in arrears for 90 days. Seventeen hospitals' policies turn a debt into bad debt at 90 days; 8 do so in less than 90 days (a few hospitals convert debt into bad debt after just 60 days); and 16 turn the bill to bad debt in over 90 days (up to 120 days). Six hospitals were silent on this issue.

Once a hospital converts an obligation into bad debt, the vast majority of hospitals in Maryland turn the bill over to a third-party debt collector—usually a collection agency or a law firm. A few Maryland hospitals specify that a third-party debt counseling service will begin working with delinquent patients before the obligation becomes a bad debt, with the goal of finding existing or potential eligibility for third-party sources of payment, identifying charity eligible patients, and establishing a payment plan.

Control and Oversight of Third Party

The February 2009 review found that most Maryland hospitals' policies simply required standard boilerplate language that a reviewer might find in any contract; namely, that the third-party contractor must comply with all applicable federal and state laws.

However, very few hospitals' policies in Maryland went beyond that to govern the behavior and practices of the third-parties hired by hospitals to collect bad debts. For example, while a few of the hospitals' policies admonished the third parties to comply with the hospital's standards, very few do. In general, once the debt is handed to a third party, the policies are silent regarding the behavior of these parties.

Garnishments, Attachments, and Liens

With respect to garnishing wages or attaching bank accounts after a court has ordered payment on an unpaid obligation, the February 2009 review found that some policies in Maryland were specific and provided authority for third-party debt collectors to take these actions on behalf of hospitals. However, a majority of hospitals were entirely silent and did not address the topic.

With respect to placing liens on property, 13 total policies in Maryland allowed third-party agents to attach liens on property, but 3 of those hospitals' policies specifically exempted the primary residence from liens. Three policies clearly prohibited the placement of any lien by a third-party, and, again, the large majority (31 hospitals) did not address the subject at all. The policies that tended to protect patients the most, generally prohibited the third-party from conducting any of these activities once a court order was obtained. Instead, these policies required the third party to return the account to the hospital for execution of the court order.

Approval of Policy

In the February 2009 review, it was learned that the agent of the hospital authorized to establish the financial assistance policy is generally the hospital's chief financial officer (CFO), chief operating officer (COO), or chief executive officer (CEO). Rarely is it stated in a policy that the hospital's board is to be involved. More specifically, five policies were signed by the hospital's Director of Patient Financial Services, 15 by the hospital CFO or COO, 13 by the hospital's President or CEO, and only two by Chair of the Board of Directors. In the policies reviewed, 12 did not identify the approving authority.

Special Audit

The February 2009 report of the HSCRC to the Governor conveyed the need to conduct special audits to discern the level of compliance with State law and assess whether there is variability in financial assistance and collection polices among hospitals in the State. In addition, Chapters 310 and 311 of the 2009 Legislative Session of the Maryland General Assembly require the HSCRC to review each hospital's implementation of, and compliance with, the information sheet and hospital collection requirements outlined in the legislation. In response, the HSCRC issued special audit procedures on February 6, 2009 to initiate the required review, and responses were returned to the Commission by March 30, 2009. The review was undertaken in three areas – Financial Assistance policies, Credit and Collection Policies, and Bad Debt Recoveries. A summary of the special audit can be found under Appendix IV

House Bill 627, which was enacted during the 2005 Legislative Session, requires hospitals to post conspicuous notices describing their financial assistance policies explaining how to apply for free or reduced-cost care. The bill also requires hospitals to develop a financial assistance policy for providing free and reduced-cost care to certain patients. The audit was designed to:

- Determine whether such notices are posted;

- Describe the content of the notices and where they are posted; and
- Determine, based on a random sample of 50 cases, the number and percentage of cases where the financial assistance policy was followed.

The Audit results show:

- All hospitals post notices conspicuously at the hospital; and
- While hospitals tend to convey that they have financial assistance policies in their postings and provide appropriate contact information, very few actually describe the financial assistance policy in the posting.
- Hospitals frequently deviated from their financial assistance policies by approving eligibility without all required documentation and also frequently grant more assistance than patients may be eligible to receive pursuant to the policies.

The HSCRC acknowledges that it is typically not feasible to provide a detailed description of the financial assistance policy on such a posting.

Of the 47 hospitals audited:

- 23 (49%) complied with their financial assistance policies 75% of the time or more;
- 10 (21%) complied with their financial assistance policies between 25% and 75% of the time;
- 14 (30%) complied with their financial assistance policies 24% of the time or less; and
- 18 (38%) of the hospitals complied between 98% and 100% of the time, while 12 (25%) complied between 0%-2% of the time.

According to the audit findings, hospitals typically deviated from their financial assistance policies by approving eligibility without required documentation and by providing more assistance than a patient may be eligible for under the stated policy.

Chapters 310 and 311 also set forth various standards and requirements for hospital collection policies. The audit questions require the auditors to report on the number of cases and the percentage of the time that hospital collection policies were followed, as well as examples of why there were deviations from these policies. The audit also asked for the number and percentage of cases where patients were granted Medicaid eligibility yet the collection process was initiated. Auditors were required to select a random sample of 50 cases over a 12-month period.

The audit found that of the 46 hospitals reporting:

- 34 (74%) complied with their collection policies 75% of the time or more;
- 6 (13%) complied with their collection policies between 25% and 75% of the time;
- 6 (13%) complied with their collection policies 24% of the time or less; and

- 17 (37%) of the hospitals complied between 98% and 100% of the time while 1 (2%) complied between 0%-2% of the time.

According to audit findings, samples of reasons for deviation from collection policies include:

- Billing statements sent too early;
- Accounts were sent to collection agency earlier than policy stated;
- Accounts were written off earlier than time period;
- Overpayment;
- Follow up calls to patients not made;
- Account not approved by appropriate personnel before assigning as bad debt;
- Not sent to collection agency until after the time period in policy; and
- Not classified as bad debt until after time period in policy.

Auditors reported that there were only six documented cases where collection policies were applied to patients who were eligible for Medicaid; however, many of the auditors were unable to determine this due to lack of documentation in the patient record. This is an issue that the HSCRC will address when it reissues this special audit in the future.

Under current practice, Maryland hospitals are required to reduce bad debt by the amount of any recoveries. Auditors were asked for the number and percentage of cases (based on a 50 case random sample) where uncompensated care was reduced by the full amounts recovered (and where the recovered amount was not reduced by collection agency fees or expenses). According to the audit results, virtually all gross recoveries were reduced from bad debts.

The Commission will continue to conduct this special audit on an annual basis.

IV. Work Group Issues Discussed, Other State Examples, Stakeholder Positions and Recommendations based on Deliberations

Section 2 of Chapters 310 and 311 of the 2009 Laws of Maryland requires the Commission to establish a Work Group on patient financial assistance and debt collection. The legislation requires this Work Group to review the following:

(1) the need for uniform policies among hospitals relating to patient financial assistance and debt collection, including as elements within any uniform policies:
    (i) income thresholds and any special treatment of disability and pension income;
    (ii) asset thresholds and treatment of various types of assets;
    (iii) use of liens to enforce collection of a debt;
    (iv) collection procedures;
    (v) establishment of guardianship;

(vi) use of judgments to collect debts; and

(vii) patient education and outreach to inform patients of the availability of financial assistance with their bills

(2) the desirability of applying any uniform policies to private psychiatric and chronic care hospitals; and

(3) the desirability of altering the legal rate of interest on a judgment to collect a hospital debt.

The Work Group reviewed recent legislation in several states considered to have established new models of oversight and new standards for financial assistance, focusing on the experience of California, Illinois, Minnesota, New Jersey, New York, and Ohio. Additional voluntary guidelines were reviewed from several states, including Massachusetts. These states are not an exhaustive list. Rather, they were selected because they have enacted fairly comprehensive legislation applying differing approaches to financial assistance and debt collection policies. Most were recently enacted. They also are considered among the most progressive states in the adoption of financial assistance and debt collection standards. To better understand the decision- making process underlying legislative language, interviews were conducted with the Illinois Hospital Association and the Illinois Office of the Attorney General as well as with California stakeholders. Findings from these reviews are reported in subsequent State Examples sections throughout the document.

The Work Group also reviewed and summarized the positions and recommendations of industry stakeholders, including the Maryland Hospital Association, American Hospital Association, Catholic Health Association, Healthcare Financial Management Association, and one consumer group, Community Catalyst, which has set forth legislative recommendations.

Many of the discussion issues center on various income ranges and patients' ability to pay for medical care more generally. To facilitate discussion, Table 1 displays the income levels associated with 150 percent, 200 percent, 300 percent, and 400 percent of the federal poverty level, as calculated by the Department of Health and Human Services 2009 Federal Poverty Guidelines. The average household size in Maryland is 2.6.

Table 1. Department of Health and Human Services 2009 Federal Poverty Guidelines

Number of Individuals in Household	150% FPL	200% FPL	300% FPL	400% FPL
1 $16,245		$21,660	$32,490	$43,320
2 $21,855		$29,140	$43,710	$58,280
3 $27,465		$36,620	$54,930	$73,240
4 $33,075		$44,100	$66,150	$88,200
5 $38,685		$51,580	$77,370	$103,160
6 $44,295		$59,060	$88,590	$118,120
7 $49,905		$66,540	$99,810	$133,080
For each additional person, add $3,740				

Each section below first illustrates activities in other states for each of the issues discussed by the Work Group as well as positions of major stakeholder groups for each issue area. Each section then concludes with the HSCRC's recommendation based on the deliberations of the Work Group.

Patient Financial Assistance Eligibility Thresholds

Chapters 310 and 311 from the 2009 Legislative Session establish a household income of 150 percent of the FPL as the minimum eligibility threshold at and under which Maryland hospitals must provide free "medically necessary" care to all uninsured patients receiving inpatient or outpatient hospital services. This threshold is in line with the minimum floor for free care recommended by the Maryland Hospital Association in voluntary guidelines established a few years ago.

As stated in Section 1(A) of Chapters 310 and 311:

(3) (I) The Commission by regulation may establish income thresholds higher than those under paragraph (2) of this subsection.

(II) In establishing income thresholds that are higher than those under paragraph (2) of this subsection for a hospital, the Commission shall take into account:

1. The patient mix of the hospital;
2. The financial condition of the hospital;
3. The level of bad debt experienced by the hospital; and
4. The amount of charity care provided by the hospital.

Chapters 310 and 311 do not establish methods that hospitals should use to calculate income, they do not indicate whether assets should be considered, and they do not define "medically necessary" care. Thus, these Chapters provide the Work Group with the task of considering whether to apply uniform policies in these areas or leave hospitals the flexibility to determine their own policies.

It is important to note that states other than Maryland typically have not regulated or set hospital rates, so that gross charges, based on list prices in hospital charge description masters (CDMs), can be well above actual costs. Thus, earlier reforms of financial assistance policies in other states have typically sought to set limits on the cost-to-charge ratio (or discount rate) that can be applied when billing the uninsured. Maryland, on the other hand, sets hospital rates through its unique all-payer system, which results in a markup of charges over cost in Maryland that is much lower than other states, in the 15 to 20 percent range, compared to an average charge of more than 300 percent of cost in some states.

This means that a standard for financial assistance in another state, when applied in Maryland, would have a different impact on Maryland hospitals with respect to the size of the invoice to patients and the claimed charitable write-off when financial assistance is provided. Thus, the

comparatively low charges in Maryland are important to consider when developing financial assistance policies and reporting.

The policies in other states that have recently taken action on income thresholds are summarized below.

California established a 350 percent of the FPL threshold below which patients are eligible for free or discounted care (without setting a minimum floor for free care), and includes as eligible both uninsured patients and insured patients with high medical costs (defined as out-of-pocket costs that exceed 10 percent of family income) under this threshold (California Health and Safety Code and California Code of Regulations).

Illinois does not establish free care thresholds in its Hospital Uninsured Patient Discount Act, but does cap eligibility for "discounts" to families with incomes below 300 percent of the FPL for rural hospitals and 600 percent of the FPL for urban hospitals. These "discounts" refer to a cap of 135 percent of the cost-to-charge ratio that can be applied when billing an uninsured patient. This cap rests above the ratio of 110 to 115 percent generally applied by hospitals to all payers in Maryland. Illinois also caps the maximum collectible amount per-person per-hospital per-year at 25 percent of family income if the family does not have substantial assets (Illinois Compiled Statutes 210.89 Hospital Uninsured Patient Discount Act).[5]

New York, like Illinois, requires sliding scale "discounted" charges to the uninsured with incomes below 300 percent of the FPL in order for a hospital to receive a Hospital Indigent Care Pool distribution. Below 100 percent of the FPL, the State establishes a nominal patient contribution amount for each type of service. For instance, there is no charge for prenatal and children's emergency room and clinic visits, whereas adults are charged $15 per adult visit to the emergency room and outpatient clinic and $150 for inpatient services. Individuals with incomes between 101 and 300 percent of the FPL must be charged on a sliding scale, which ranges from the nominal fees described above to the highest amount paid by the highest volume payer (New York Public Health Law 2807).

New Jersey's Hospital Care Payment Assistance Program extends free care to uninsured individuals with incomes at or below 200 percent of the FPL (some services are excluded). Care is discounted using a sliding scale for uninsured individuals with incomes between 201 and 300 percent of the FPL, paying between 20 and 80 percent of the charge. Out-of-pocket payment is capped at 30 percent of annual family gross income in a 12-month period (New Jersey Department of Human Services, 2005).

[5] Many of the thresholds arrived at in legislation reflect the limits of political consensus. The final language was merely perceived as an improvement over the status quo, not a model for future legislation. Interview with David Buysse, Deputy Division Chief, Public Interest Division, Illinois Office of the Attorney General, July 9, 2009.

Ohio's Hospital Care Assurance Program requires all hospitals receiving Medicaid disproportionate share funds to offer free services to individuals with incomes below 100 percent of the FPL who do not qualify for Medicaid (Ohio Administrative Code).

Minnesota's voluntary agreement with the Minnesota Hospital Association recommends a threshold for free care of 200 percent of the FPL. Minnesota also limits hospital charges to uninsured individuals with annual household incomes less than $125,000 to the maximum amount they charged their largest insurer for the same service in the previous year (Minnesota Hospital Association, 2005).

The policies of stakeholder groups on this topic are as follows.

The Maryland Hospital Association (MHA), in its voluntary guidelines for financial assistance policies, specifies that, as a minimum, individuals with incomes below 150 percent of the FPL should receive free care and recommends extending discounts to individuals with incomes up to 200 percent of the FPL. The extent of the discount is not specified, but MHA recommends that hospitals consider the size of the bill and ability to pay in developing financial assistance policies (Maryland Hospital Association).

The Healthcare Financial Management Association (HFMA), in its Principles & Practices Board Statement 15, states that a single eligibility threshold for financial assistance would not be universally applicable to all hospitals, and that each hospital should consider its own mission, community characteristics, and financial status in determining financial assistance policies. Eligibility for financial assistance should be based on factors other than the federal poverty guidelines, such as employment status, living expenses, and other health care bills. Hospitals should consider granting free-care to certain patients on a presumptive basis if, for example, they have one or more characteristics that indicate inability to pay (e.g., they already have been qualified for a means-tested government health or human services program or are homeless). (Healthcare Financial Management Association, 2009 and 2006).

The Catholic Health Association (CHA), in its guidance on community benefits, states that charity care should be reported on the basis of *costs* (actual financial losses to the hospital) rather than *charges,* and that discounts should consider the actual cost of the care provided to patients qualifying for financial assistance.. Applied to Maryland, this would mean that patients eligible for reduced-cost care or for medical hardship assistance would have their medical bills calculated at cost with no markup – or below cost. If discounts are not below-cost, the hospital is not in fact granting charity care. (Catholic Health Association).

Community Catalyst, in its sample financial assistance policy, recommends, at a minimum, that individuals with incomes below 200 percent of the FPL be eligible for free care. Individuals with incomes between 201 and 400 percent of the FPL should receive "partial free care." In this range, individuals pay an amount equivalent to 20 percent of the portion of their income that exceeds the free care threshold of 200 percent of the FPL (Community Catalyst 2003 and 2004).

Taking these policies and the deliberations of the Work Group into account, the following Patient Assistance Eligibility Thresholds are recommended:

Recommendations on Patient Assistance Eligibility Thresholds

1. Free care shall be available to uninsured patients who otherwise are not eligible for public insurance with gross household income up to at least 200 percent of the federal poverty level (FPL).
    - **Household** is defined as the patient, the patient's spouse living in the household, and all of the patient's dependents who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), anyone claiming the patient as a dependent, and the parent(s) other dependents living in the patient's home.
    - **Gross Household income** is defined as a household's total income from all sources, including, without limitation, gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, family-owned business interests, royalties, estates, trust funds, child support, and alimony.
2. Hospitals can request a lower standard (no lower than 150 percent of the FPL), but must demonstrate to the HSCRC that a standard of 200 percent of FPL would yield undue financial hardship to the hospital.
3. If a hospital has collected more than $25 from a patient (or the patient's guarantor) who, within a 2-year period after the date of service, was found to be eligible for free care on the date of service, the hospital must refund to the patient (or the patient's guarantor) the amount collected above $25. Likewise, if a judgment or adverse credit report has been entered on a patient who was later found to be eligible for free care on the date of service, the judgment or adverse credit report shall be vacated and stricken.
    - This policy excludes patients with a means-tested government health care plan that requires the patient to pay out-of-pocket for selected healthcare services.
    - This policy is predicated on the patient complying with his/her responsibilities under Section I.G. of these recommendations.
    - The 2-year period under this policy may be reduced to no less than 30 days after the hospital requests relevant information from the patient in order to make a determination of eligibility for financial assistance, if documentation exists of the patient's (or the guarantor's) unwillingness or refusal to provide documentation, or the patient is otherwise uncooperative regarding his/her patient responsibilities.
4. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free care, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days:
    - Households with children in the free or reduced lunch program
    - Supplemental Nutritional Assistance Program (SNAP)

- Low-income household energy assistance program
- Primary Adult Care Program (PAC) (until such time as inpatient benefits are added to the PAC benefit package)
- Women, Infants & Children (WIC)

5. The HSCRC may specify through regulation that patients who are beneficiaries/recipients of additional means-tested social services programs are eligible for free care as appropriate.
6. Hospitals may use additional presumptive eligibility criteria to deem patients eligible for free care.
7. Discounts shall be available to uninsured patients with household income up to at least 300 percent of the FPL.
8. Hospitals can request a lower standard for reduced cost care, but must demonstrate to the HSCRC that a standard of 300 percent of FPL would yield undue financial hardship to the hospital.
9. The maximum patient payment for reduced-cost care shall not exceed the charges minus hospital's aggregate markup.
10. Hospitals shall provide a mechanism whereby patients may have hospital decisions regarding the granting of financial assistance and the establishment of payment plans reconsidered.

Special Treatment of Certain Categories of Income and Assets

Section 2 of Chapters 310 and 311 of the 2009 legislation specifically requests input on the special treatment of certain categories of income and assets. The legislation identifies the need for uniform policies among hospitals relating to patient financial assistance and debt collection, including as elements within any uniform policies:

(i) any special treatment of disability and pension income
(ii) asset thresholds and treatment of various types of assets.

Most state legislation reviewed did not specifically address the treatment of disability and pension income in determining eligibility for financial assistance. Illinois SB 2380 states that any amounts held in a pension or retirement plan may be excluded from the calculation of assets. That legislation also states that that retirement and pension distributions may be counted as income.

California indicates that hospitals may consider assets in determining eligibility. The legislation specifies, however, that the following assets are excluded: retirement or deferred compensation plans, the first $10,000 of monetary assets, and 50 percent of monetary assets over $10,000.

Illinois also allows hospitals to consider assets in determining financial assistance eligibility; an individual's assets may not exceed the income thresholds for financial assistance (600 percent of the FPL in urban areas and 300 percent of the FPL in rural areas). The following may not be counted

toward the asset test: primary residence, any amounts held in a pension or retirement plan, and property exempt under other state laws.

New York is similar to California in that assets *may* be considered, but the New York Department of Health reports that most hospitals consider income alone in determining eligibility for discounts. The following assets are excluded: primary residence, tax deferred/retirement savings accounts, college savings accounts, and cars used by patients and their immediate family members.

In order to receive financial assistance in **New Jersey,** an individual's assets may not exceed $7,500, and family assets may not exceed $15,000. The primary residence is excluded from the asset test.

Ohio does not impose an asset test in determining eligibility for free care unless the hospital policy requires it.

Maryland does not perform asset tests in determining Medicaid eligibility for pregnant women, children, and most family coverage groups. Asset tests are also excluded from determining eligibility for the Primary Adult Care (PAC) program and the Maryland Children's Health Program (MCHP).

The stakeholder policies in this area are as follows:

MHA voluntary guidelines state that individuals must have less than $10,000 in net assets in order to qualify for financial assistance. No asset class is protected or excluded from consideration.

HFMA's sample financial assistance policy uses the Census Bureau's definition of family income, which includes veterans' payments, survivor benefits, pension income, and retirement income in determining eligibility for financial assistance.

Community Catalyst recommends that there be no asset test for individuals to qualify for free or discounted care up to 400 percent of the FPL (the proposed upper income limit for eligibility for discounted care). This recommendation is based on research suggesting that individuals within this range typically have very limited assets (Weissman, Dryfoos, & London, 1999). Community Catalyst does recommend an asset test for medical hardship assistance. This asset test excludes the following: primary residence, primary motor vehicle, burial contracts, certain amounts of life insurance, certain amounts of retirement assets, and $4,000 of other assets (individuals).

Medicare sets some general guidelines for determining whether a beneficiary is either indigent or medically indigent. Notably, the provider "should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses," as well as "any extenuating circumstances" (Centers for Medicare and Medicaid Services, n.d., p. 316).

Taking these policies and the deliberations of the Work Group into account, the following provisions regarding the Special Treatment of Categories of Income and Assets are recommended:

Recommendations on Special Treatment of Categories of Income and Assets

1. A hospital may, in its discretion, consider household monetary assets in determining eligibility for financial assistance in addition to the income-based criteria, or it may choose to use only income-based criteria. If a hospital chooses to utilize an asset test, that test must adhere to the following bulleted items:

   - "Monetary assets" are those assets that are convertible to cash excluding a primary residence, and retirement assets, which are defined to be those assets (such as a 401K) where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans.
   - A principal residence may be considered in making a financial assistance determination after first excluding a "safe harbor" equity in the home in the amount of $150,000.
   - At a minimum, the first $10,000 of monetary assets may not be considered when determining eligibility for free or reduced cost care.

Medical Hardship Assistance for Medically Indigent Patients

Beyond the income ranges for which hospitals provide financial assistance, some uninsured and underinsured higher-income patients may incur catastrophic medical bills not covered by insurance which are so large that even a person with relatively high income could have difficulty paying the bill in full. These individuals would be considered "medically indigent." Based on a review of Maryland financial assistance policies submitted to the Commission, 27 hospitals had a policy on "catastrophic" expenses for patients deemed "medically indigent." Policies that provide assistance to the medically indigent are referred to as medical hardship assistance.

Most states examined do not explicitly address a medically indigent class of patients. The exception is **California**, where hospitals may provide indigence assistance to individuals whose household incomes do not exceed the financial assistance threshold (350 percent of the FPL), and who does not receive a discounted rate from the hospital as a result of third party coverage, and whose medical costs are more than 10 percent of family income. Rural hospitals are allowed to set a lower standard for indigence assistance.

However, several states apply an income range within which patients can be eligible for discounted care that could be interpreted to include patients who are insured but medically indigent. When eligibility determination methods for these ranges are not legislated or regulated, the states essentially allow hospitals to apply different eligibility standards and different discounting methods across the discounted range. Thus, hospitals might choose to qualify patients at the highest range of income for discounted care only if they meet a medically indigent standard.

California's medical hardship policy caps *annual* out-of-pocket expenses per person per whose family income does not exceed 350% of the FPL at 10 percent of family income for *the prior 12 months*.

Some examples include **Minnesota**, which limits hospital charges to uninsured individuals with annual household incomes less than $125,000 to the maximum amount paid by an insurance company in the previous calendar year; **Illinois**, which caps the maximum collectible amount per-person per-hospital per 12 month period at 25 percent of family income (patients with high deductible health plans are not eligible); **New York**, which caps fees for individuals with incomes below 300 percent of the FPL at the highest amount paid by the highest volume payer; and **New Jersey**, which restricts charges for care to 80 percent of the charge for uninsured individuals below 300 percent of the FPL, and caps out-of-pocket payment at 30 percent of annual family gross income in a 12-month period.

Stakeholders groups have issued the following guidelines:

MHA recommends that hospitals consider the size of the bill and ability to pay in developing financial assistance policies.

HFMA states that medical hardship, including the amount and frequency of medical bills, should be considered when developing financial assistance policies.

Community Catalyst recommends a formula to provide medical indigence assistance to individuals with incomes higher than the financial assistance threshold. For those with incomes over 400 percent of the FPL, the maximum collectible amount would be equal to 25 percent of income for the calendar year, unless family assets are sufficient to cover bills exceeding this amount.[6]

Medicare sets some general guidelines for determining whether a beneficiary is either indigent or medically indigent. Notably, the provider "should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses," as well as "any extenuating circumstances" (Centers for Medicare and Medicaid Services, n.d., p. 316).

Taking these policies and the deliberations of the Work Group into account, the following provisions regarding the Medical Hardship are recommended:

Recommendations on Medical Hardship

1. Medical debt for out-of-pocket expenses (excluding copays, deductibles and coinsurance) for uninsured or underinsured patients (incurred over a 12-month period) cannot exceed 25% of household income. For example, if one or more patients in a household earning $60,000 per year receives hospital bills in the amount of $40,000, the maximum out-of-pocket medical debt for non-covered medically necessary services is $15,000, less any applicable copays, deductibles and coinsurance (25 percent of $60,000), and $25,000 must

[6] For example, an individual in a family of one whose annual income is $25,000 would pay a maximum of $668 for hospital services, and then receive free care for any amount over $668 in that calendar year. This calculation is based on the United States Department of Health and Human Services 2009 Federal Poverty Guidelines.

be written-off as charity care. Any payment plan for the patients in this household would be premised on the $15,000 in household out-of-pocket debt. To be eligible to have this maximum amount applied to subsequent charges, the patients shall inform the hospital in subsequent admissions or outpatient encounters that one or more members of the household has previously received health care services from that hospital and was determined to be entitled to the discount.

- Medical debt includes all medical costs (excluding copays, deductibles, and coinsurance) for which the hospital billing office is responsible to bill. Therefore, if a hospital does not bill for physician services, physician costs may be excluded by the hospital when calculating the medical debt.

- Hospitals may adopt policies to exclude a patient from the application of the medical hardship policy when the patient has income that exceeds 500% of FPL.

- For patients whose household income falls in the income range between 200% and 300% of FPL, if the medical hardship policy would result in a more patient-friendly reduction than the reduced cost policy (found above), the medical hardship policy would apply.

- When distributing amounts collected from patients under this section between the hospital and physician(s) (for medical costs that the hospital billing office is responsible for billing), the hospital shall not distribute to the physician an amount greater than:

    - For an insured patient, the amount paid by the patient's insurer; or

    - For an uninsured patient, what would otherwise be paid to the physician under the Medicare fee schedule for the services provided.

Collection Procedures, Protection from Collection Action, and Use of Judgments to Collect Debts

Section 1 of Chapters 310 and 311 of the 2009 Laws of Maryland mandates that hospital policies on the collection of debts owed by the patient shall:

(1) provide 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) describe the hospital's procedures for collecting a debt; and
(6) describe the circumstances under which the hospital will seek a judgment against a patient.

The Commission construes this law to apply to any agency hired by a hospital to collect debts and will hold hospitals accountable should their agents violate these provisions. Chapters 310 and 311

request input from the Workgroup on "the need for uniform policies among hospitals related to …debt collection, including as elements within any uniform policies:

> (iii) use of liens to enforce collection of a debt;
>
> (iv) collection procedures;
>
> (v) establishment of guardianship;
>
> (vi) use of judgments to collect debts; and
>
> (vii) the desirability of altering the legal rate of interest on a judgment to collect a hospital debt."

California does not permit hospitals to submit unpaid bills for collection if a patient is attempting to qualify for financial assistance or a payment plan. Hospitals must allow for 150 days after billing before pursuing civil action or adverse credit reporting for the uninsured or patients with high medical costs.

In **Illinois**, before pursuing collection action against the uninsured, hospitals must first allow the patient to apply for financial assistance and offer a payment plan unless the agency has agreed to comply with certain regulations. The patient must be allowed 60 days to submit an application for financial assistance, and the payment plan must be offered for the 30 days following the initial bill. Hospitals may proceed with collection after these time periods. Collection actions may not be pursued without the written approval of an authorized hospital employee (Illinois Public Act 094-0885 Fair Patient Billing Act).

New York hospitals may not send an account to collection if a patient has an application pending for financial aid. Collection action against patients deemed eligible for Medicaid at the time of service is also prohibited. Hospitals must offer payment plans for outstanding balances by discount recipients. Collection agencies must obtain the hospital's consent prior to commencing legal action.

New Jersey prohibits collection action against individuals eligible for free care; individuals eligible for discounted care may not be subject to collections for amounts above the discounted fee.

In **Minnesota,** prior to collection action, hospitals must first ensure that all third parties/insurance companies have been billed, the patient has been offered a payment plan; and the patient has been offered any financial assistance for which he or she may be eligible.

Massachusetts recently revised community benefit guidelines to take effect in October 2009, which recommend no collection action prior to 120 days after the first bill is sent. The recommendations also provide that the hospital should establish a mechanism for patients to complain directly to the hospital about the behavior of collection agents, and the hospital should allow patients to negotiate directly with the hospital and pay the hospital directly, even after a matter might have been referred to a third-party collection agent. The guidelines also recommend that hospitals seek approval from their board of directors before reporting a patient's medical debt to a credit or reporting agency and must seek to remove the bad credit report upon payment (Massachusetts Office of Attorney General).

Missouri passed a law in 2007 that permits hospitals (and other health care providers) to be paid from the proceeds of any tax refund the patient/taxpayer might receive. The law requires hospitals to allow at least 90 days for payment before referring the unpaid bill to the State Department of Health and Senior Services (DHSS). If the debt appears to be meritorious "on its face," DHSS certifies the debt to the State Department of Revenue, which is obligated to satisfy the debt before awarding any refund to the patient/taxpayer.

Stakeholder recommendations on collections include:

MHA does not have any guidelines pertaining to credit and collection policies.

In its sample policy, **HFMA** recommends that collection actions consider the extent to which the individual qualifies for financial assistance and the patient's efforts to qualify for financial assistance and government assistance programs. For patients who qualify for financial assistance and who are cooperative in resolving their bills, HFMA suggests that hospitals establish payment plans and not send unpaid bills to collection.

Community Catalyst states that government assistance enrollees, individuals with applications pending for government assistance programs, and free care recipients should be exempt from collections. Further, discount care and medical hardship assistance recipients are exempt from collections over the discounted amount. Payment plans should be established for individuals who are not eligible for financial assistance. All collection actions must be approved by the hospital board, and all hospital collection policies apply to all third parties. If a collection action is initiated and the individual is subsequently determined eligible for free care, the hospital is required to refund any money the individual already paid.

The Access Project, in their testimony at a Congressional hearing on medical bankruptcy and medical debt, posit that involuntary medical debt should not tarnish an individual's credit report, and that medical debt should not be reported to credit agencies (Rukavina, 2007).

Taking these policies and the deliberations of the Work Group into account, the following provisions regarding the Collection Procedures, Protection from Collection Action, and Use of Judgments to Collect Debts are recommended:

Recommendations on Collection Procedures, Protection from Collection Action, and Use of Judgments to Collect Debts

1. Upon request, the hospital shall provide the person with a written estimate of the total charges for the hospital services, procedures, or supplies that are reasonably expected to be provided and billed to the person by the hospital. It shall be clearly stated that this is an estimate and that actual charges could vary. The hospital may provide this estimate during normal business office hours. This section shall not apply to emergency services provided to a person.
2. A hospital shall provide patients with clear information (including on all bills) on how to contact the hospital to inquire or to dispute a bill and shall respond to patients' inquiries

within 30 days. The hospital shall make this information available in all of the languages for which the hospital provides onsite interpreter services (limited English proficient population that constitutes at least 3% of the hospital's service area).

3. If a hospital delegates collection activity to an outside collection agency, it shall do so by means of an explicit authorization or contract to do so and shall require that the third party agree to abide by the hospital's credit and collection policies and shall specify procedures the collection agency will follow if patients appear to qualify for financial assistance.
4. Hospitals shall assure that third party collection agents will provide the patient with an opportunity to file a grievance or complaint and will forward all grievances or complaints to the hospital regarding the bill or the conduct of the collection agent.
5. The Commission's review revealed no legislation or stakeholder positions that addressed the question of how or when hospitals should establish guardianship. **Medicare** debt collection rules require that the provider "must determine that no source other than the patient would be legally responsible for the patient's medical bill" (Centers for Medicare and Medicaid Services, n. d., p. 316). No recommendations were made regarding this issue.
6. For an uninsured patient, or for a patient who provides information that he or she may be a patient with high medical costs, a hospital or any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 120 days after the first initial patient bill (excluding the Maryland summary statement) unless documentation exists of the patient's (or the guarantor's) unwillingness or refusal to pay, or the patient is uncooperative in meeting patient responsibilities.
    - Unless documentation exists of the patient's (or the guarantor's) unwillingness or refusal to pay, or the patient is uncooperative in meeting patient responsibilities, the hospital or the hospital's contracted third party shall continue to work with patients to resolve billing issues including entering into payment plans.
7. Hospitals and their third party collection agents shall remove relevant patient debt items from the patient's credit report once that debt is paid in full.
8. Hospitals shall offer uninsured patients with income between 200 percent and 500 percent of the FPL who request assistance the opportunity to enter into a payment plan for their hospital care, and the period of time and monthly payments for this payment plan must be reasonable. Any extended payment plans offered by a hospital to assist patients eligible under the hospital's financial assistance policy shall be interest free.

Interest Rates on Medical Debt

Under current Maryland law, hospitals are prohibited from charging interest on bills incurred by self-pay patients before a court judgment is obtained. State law also (CJ 11-107) establishes the interest rate for all judgments (health care and otherwise) to be 10%. Currently, post-judgment interest rates in Maryland are capped at 10 percent per annum. Pre-judgment and Post-judgment interest rate requirements in Maryland can be found in Appendix V.

California requires extended payment plans offered by hospital assistance policies to be interest free.

New York states that interest on monthly payment plans may not exceed the U.S. Treasury rate for 90-day securities plus .5 percent. Additionally, New York explicitly prohibits accelerators for missed payments.

Minnesota's voluntary agreements do not address interest rates. However, preexisting state law imposes a cap on interest rates of 8 percent per annum on "any legal indebtedness" formalized by any written agreement (Minnesota Statute § 334.03 (2008).[7]

Community Catalyst proposes that interest rates in payment plans be capped at the lesser of 3 percent or the consumer price index. Additionally, hospitals should inform patients on the difference between the payment plan interest rate and the rates charged by credit card companies.

Recommendation on post-judgment Interest for Medical Debts

1. There should not be any change to the pre-judgment or post-judgment interest rules or rates.

Use of Liens, Garnishment, and Attachment

The Work Group engaged in much discussion regarding the execution liens on residences in Maryland. Representatives of the Legal Aid Bureau summarized existing law in Maryland. In general, the entry of a judgment is governed by the Maryland Rules. When one party sues another party, the Maryland Rules apply to the process of filing the suit, entry of the judgment, and collection on the judgment. Lawsuits filed in the Circuit Court are governed generally by Chapter 2 of the Maryland Rules, and lawsuits filed in the District Court are governed generally by Chapter 3 of the Maryland Rules. A judgment is a determination by a Court in favor of a party to a lawsuit, and a money judgment is a determination that a certain amount of money is immediately payable to the judgment creditor (Ann. Code of Md., Cts. & Jud. Proc. §11-401(c)).

When a judgment is entered by a court, the prevailing party will want to ensure that the judgment is recorded; for once it is recorded, it can become a judgment lien on real property. The judgment once recorded will become a lien on land that is currently held by the judgment debtor or future land that the debtor may purchase or inherit.

A judgment creditor cannot sell land that is held as tenants by the entireties if it holds a judgment against just one tenant. Tenants by the entireties property is property jointly held as husband and wife. If property is held as joint tenants, the judgment lien cannot attach until after the joint tenancy is severed (*Eastern Shore Bldg. & Loan Corp. v. Bank of Somerset,* 253 Md. 525, 253 A. 2d 367 (1969)).

[7] In the absence of a written agreement specifying a higher rate, Minnesota's interest cap is 6 percent.

There are three categories of creditors – priority, secured and unsecured. A priority creditor is typically one that a legislative body has determined has a special status and must be paid before all other creditors or be granted a lien. Examples of such creditors are taxing authorities or municipalities. A secured creditor is one who has a right to personal or real property because of a consensual agreement between the parties whereby one party has granted a consensual lien to another in exchange for some consideration, usually money. A typical example of a secured creditor is a mortgage company or a company that has financed a vehicle. The creditor who has priority to real property is the creditor who has received a judgment and recorded first. In a typical scenario, a consumer debtor who owns a house will have a mortgage on the house, and that mortgage company will have filed the Deed of Trust with the county (or Baltimore City) land records. Any creditor who sues the consumer debtor thereafter and records in time and as permitted by the Maryland Rules will have priority over other creditors, except the mortgagee or the holder of a tax lien. A more detailed summary of the Maryland law regarding liens on residences that was presented to the Work Group can be found in Appendix VI.

Other states' provisions on liens, garnishment, and attachments include:

In **California**, wage garnishments and liens are not allowed for financial assistance patients. For other patients, wage garnishment is not allowed without a court order. Additionally, the sale of a patient's primary residence during his or her lifetime is prohibited.

Illinois did not address the use of liens or garnishments in recent legislation. However, prior state law limited the amount of liens by health care professionals and providers (Illinois Compiled Statutes 710 ILCS 23. Health Care Services Lien Act). According to staff at the Attorney General's Office, the use of liens was not pursued in recent legislation in order to focus political consent on the most pressing issues.

In **New York**, forced sale or foreclosure on a primary residence is not allowed in order to collect on an outstanding medical debt.

Minnesota specifies that wages and bank accounts may be garnished after obtaining a judgment against the patient.

HFMA specifies that hospitals shall not garnish wages or place liens on the primary residence of individuals who qualify for financial assistance.

Community Catalyst states that government assistance enrollees, individuals with applications pending for government assistance programs, and free care recipients should be exempt from collections. Thus, these individuals would be exempt from garnishments, liens, and attachments. Liens, foreclosures, wage garnishment, and any attachment of a bank account or other personal property should not be allowed without the approval of the hospital board.

Taking these policies and the deliberations of the Work Group into account, the following provisions regarding the Use of Liens, Garnishments, and Attachments are recommended:

Recommendations on Use of Liens, Garnishments, and Attachments

- Hospitals' credit and collection policies shall provide detailed procedures for the following actions:
  - When a patient debt may be reported to a credit reporting agency (in compliance with #3 above);
  - When legal action may commence regarding a patient debt (in compliance with #3 above);
  - When garnishments may be applied to a patient's or patient guarantor's income; and
  - When a lien on a patient's or a patient guarantor's personal residence or motor vehicle may be placed.
- Under current law, it is permissible for a hospital to secure a lien on a principal residence. The hospital shall not permit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical debt. Provided a hospital timely records any lien on a principal residence, a hospital shall maintain the right to defend its legal position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

Patient Education and Outreach on Availability of Financial Assistance

Section 2(a)(1) of Chapters 310 and 311 requests input from the Workgroup on the need for uniform policies among hospitals related to: "patient education and outreach to inform patients of the availability of financial assistance with their bills."

Many points regarding financial assistance notification are already addressed in Chapters 310 and 311. Other provisions in the legislation require each hospital to develop an information sheet containing certain content and indicates that "the information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative: (I) before discharge; (II) with the hospital bill; and (III) on request." Under authority of Chapter 310 and 311, the Commission has already established uniform requirements for the information sheet (Information Sheet Guidelines and Q&A can be found in Appendix II). Policies on "patient education and outreach" could encompass:

(1) What language(s) should notifications be written in;
(2) Whether the Commission should provide uniform language for all notifications;
(3) Whether notification requirements should apply to services other than inpatient;
(4) Additional notification requirements beyond the initial patient bill;
(5) Whether outreach includes a requirement to facilitate application for Medicaid for certain patients, or simply requires patient education on how to apply; and
(6) Readability of documents (based on type size and density, reading level, etc.).

California law states that hospitals must post notices about financial assistance policies in locations

that are visible to the public, including the emergency department, billing office, admissions office, and other outpatient settings.

Illinois requires hospitals to post signs about financial assistance in admission and registration areas, provide written materials such as brochures and applications in these areas, and publish notice on the hospital's website. The policy must also be included on each bill, invoice, and summary of charges. Signs must be posted in English and any other primary language spoken by at least 5 percent of patients served by the hospital.

New York law requires hospitals to ensure that every patient is made aware of their financial assistance policies. All hospitals must provide a written summary of these policies in a timely manner to all patients upon request. General hospitals with 24-hour emergency departments are required to post language-appropriate signs in the hospital facility and provide this information on bills and statements sent to patients. Specialty hospitals with 24-hour emergency departments must provide written materials to patients upon registration or intake and prior to service provision.

New Jersey requires hospitals to provide all patients with written notice about the availability of financial assistance and medical assistance programs through a form provided by the state's health department. This notice should be provided at the time of service but no later than the first bill.

Ohio states that hospitals must post notices about their free care policies in the facility, including admissions areas, business offices, and emergency rooms. These materials must be posted in clear and simple terminology in English and other languages that are common to the service area. Additionally, these notices must be clearly readable at least 20 feet away from the viewpoint of patients.

Massachusetts recommends that hospitals provide information about all available financial assistance programs at intake and on all bills. This information should be in English and all other languages for which the hospital provides on-site interpretation services. The recommendations in Massachusetts also state that the hospital bill should contain sufficient detail to enable the patient to determine if the charges are accurate, and the bill should explain that the patient has the right to dispute the bill (and how to do so) and to get a response from the hospital within 30 days.

Stakeholder groups have policies and guidelines as follows:

MHA states that hospitals should provide written notification about financial assistance polices, such as signs and brochures. These policies should be published annually in a public forum and should be available upon request. Written notices should be available in English and additional languages appropriate to the hospital's service area and should include contact information (such as a telephone number) for the hospital.

HFMA, in their sample policy, recommends that financial assistance policies be disseminated through various means, such as notification in patient bills, signage posted throughout the facility,

notification on the hospital's website, and notification in other public places. These materials should be provided in the primary languages spoken in by the hospital's service population.

Community Catalyst emphasizes that every patient should be notified of the hospital's financial assistance policies at multiple points during the admission, treatment, and billing process, including signage posted throughout the facility, publication on the hospital's website, and publication to the broader community, such as quarterly publication in local newspapers and to all community health centers. Materials should be published in English and at least five other languages spoken in the hospital's services area.

Taking these policies and the deliberations of the Work Group into account, the following provisions regarding Patient Education and Outreach are recommended:

Recommendations on Patient Education and Outreach

1. The information sheet and posted notice to patients shall include information on patients' right to apply for financial assistance and contact information.
2. A hospital must post conspicuous notices of its financial assistance policy in the billing office, inpatient and outpatient admitting/registration, and emergency department. Current law requires that these postings "describe the financial assistance policy." This shall be interpreted to mean "to notify patients of the availability of financial assistance programs."
3. The posted notice must be reasonably legible, no smaller than 8.5 by 11 inches, and in languages spoken by any limited English proficient population that constitutes at least 20% of the a hospital's service area.
4. The hospital must provide interpreter services in languages spoken by any limited English proficient population that constitutes at least three percent of a hospital's service area population to assist those patients with financial assistance and billing questions.
5. The information sheet shall also be available in languages spoken by any limited English proficient population that constitutes at least three percent of a hospital's service area population.
6. The following patient responsibilities should be added to the HSCRC's guidelines for the Information Sheet:
    - To receive financial assistance benefits, a patient responsible for paying a hospital bill must act reasonably and cooperate in good faith with the hospital by providing the hospital, and any third party agents with which the hospital has a valid collection agreement, with all of the reasonably requested financial and other relevant information and documentation needed to determine the patient's eligibility under the hospital's financial assistance policy. Reasonable payment plan options should be offered to qualified patients within 30 days of a request for such information.
    - A patient responsible for paying a hospital bill shall communicate to the hospital and any third party agents with which the hospital has a valid collection agreement any material change in the patient's financial situation that may affect the patient's ability

to abide by the provisions of an agreed-upon reasonable payment plan or qualification for financial assistance within 10 days of the change.

- To receive financial assistance, an uninsured patient may be required by the hospital to apply first for coverage under public programs (such as Medicare, Medicaid, State Children's Health Insurance Program or other programs) if there is reasonable basis to believe that the uninsured patient may be eligible for such program.

Special Treatment of Private Psychiatric and Chronic Care Hospitals

Section 2 of Chapters 310 and 311 direct the Workgroup to review "the desirability of applying any uniform policies to private psychiatric and chronic care hospitals." Both psychiatric and chronic care hospitals are classified as special hospitals under state regulations. Maryland has seven chronic care hospitals (five private and two public), which account for a total of 567 beds. In both the private and public facilities, approximately 85 percent of chronic care hospital discharges are covered by Medicare and Medicaid (Maryland Health Care Commission, 2007).

Maryland has five private psychiatric hospitals, which account for 535 or 22.3 percent of all psychiatric beds in the State. Psychiatric hospitals have different bed licensure and payment rate-setting requirements than general acute hospitals. Private psychiatric hospitals in Maryland provide acute psychiatric services. Long-term and forensic psychiatric care is provided only in state psychiatric hospitals. Payment mechanisms for psychiatric services in Maryland have recently changed. In 2007, the Centers for Medicare and Medicaid Services (CMS) did not renew Maryland's Institutions for Mental Disease (IMD) waiver, so Medicaid will no longer pay for adult treatment in private psychiatric hospitals. However, Maryland's public mental health system, through extra appropriations in 2008, will continue to pay the Medicaid rate with State general funds for Medicaid enrollees.

Referral practices for individuals who present to general acute care hospital emergency rooms depend on whether or not the hospital has a psychiatric unit and the individual's insurance status. Uninsured individuals who present to general acute hospital emergency rooms without psychiatric units are transferred to other general acute hospitals with psychiatric units or to a state psychiatric hospital. To reduce this burden on State hospitals, the Mental Hygiene Administration (MHA) has a program for purchasing beds in private psychiatric facilities for uninsured persons referred from general acute hospitals (Maryland Health Care Commission, 2008).

Private Psychiatric hospitals in Maryland are not under the State's Medicare Waiver; therefore, uncompensated care costs are borne by private payers only – making the challenges of providing charity care different for psychiatric hospitals. Recent State budget cuts may result in an increased volume of uninsured patients to these hospitals.

Financial assistance and collection policy reforms in other states have not explicitly addressed the special treatment of these types of hospitals.

California requirements apply to general acute hospitals, psychiatric acute hospitals, and special hospitals.

Illinois legislation does not exclude psychiatric or chronic care hospitals from financial assistance requirements. According to interviews with Illinois officials, psychiatric and chronic care hospitals in the State primarily serve Medicaid and privately insured patients. It was noted that some general community care hospitals in the Chicago area converted to chronic care hospitals after the passage of recent legislation, thus reducing the number of uninsured patients and the accompanying provision of financial assistance.

Ohio's financial assistance requirements apply to all hospitals receiving Medicaid payments. The laws in **New York** and **New Jersey** explicitly apply to general hospitals only.

The stakeholder policies reviewed did not address this issue.

Taking these policies and the deliberations of the Work Group into account, the following provisions regarding the Treatment of Private Psychiatric and Chronic Care Hospitals are recommended:

Recommendations regarding the treatment of Private Psychiatric and Chronic Care Hospitals

1. The recommendations of this report shall apply to Maryland's Chronic Care Hospitals.
2. Financial assistance and collection policy recommendations should be deferred for private psychiatric hospitals.

Miscellaneous Policies and Reporting Requirements

During the course this review, several items were revealed and discussed outside of the specific issues addressed in Chapters 310 and 311 but are germane to proposing proper standards for ensuring appropriate oversight and accountability of financial assistance polices and collection practices at Maryland hospitals.

In a 2008 survey, the HSCRC found that the hospital CFO, COO, or CEO generally approves the financial assistance policies for the hospital. Rarely is it stated in a policy that the hospital's board is to be involved. The HSCRC strongly believes that the fiduciary responsibility of hospital boards of directors extends to review and approve financial assistance and collection policies on a periodic basis. This is not to suggest that the board should manage the financial assistance and credit collection process, but to be aware of and approve the overall policy.

The One-e-App System is currently being used in three states and is a web-based system for connecting citizens with appropriate publically funded health and community service programs. The system is designed to screen individuals and families, via an interview process through "community assistors," for eligibility in a range of programs. The Healthy Howard Access Plan has begun to utilize the program, but further development and refinement is necessary before the system

will be fully integrated and ready for use on a large scale throughout the State. Also, further training will be necessary to have an adequate number of "community assistors" available to manage the process. When fully operational, the system can help hospitals standardize the eligibility process for both public programs as well as hospitals' financial assistance policies.

In addition, the Work Group discussed the documents required in other states for individuals to prove income, assets, and/or residency in order to quality for financial assistance. Legislation in other states is discussed below, followed by stakeholder positions.

California states that documentation of income shall be limited to recent pay stubs or income tax returns. Documentation of assets may include information on all monetary assets, excluding information on retirement or deferred compensation plans. Hospitals may require releases from the patient or his or her family, allowing the hospital to obtain information from financial/commercial institutions and other entities that hold or maintain the assets.

Illinois provides very specific documentation requirements. Any one of the following items may be used to verify income:

- Most recent tax return
- Most recent W-2 and 1099 forms
- Two most recent pay stubs
- Written income verification from an employer if paid in cash
- One other reasonable form of third party income verification deemed acceptable to the hospital

Asset verification may include:

- Statements from financial institutions or some other third party verification
- If no third party verification exists, the patient shall certify as to the estimated value of assets

Residency verification may include any one of the following:

- Any of the income documents listed above
- A valid state-issued identification card
- A recent residential utility bill
- A lease agreement
- A vehicle registration card
- A voter registration card
- Mail—from a government or other creditable source—addressed to the uninsured patient at an Illinois address
- A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
- A letter from a homeless shelter

New Jersey requires individuals to provide documentation of identification, state residency, income, and assets. Any one of the following documents may be used to prove identification:

- A driver's license
- A voter registration card
- A union membership card
- An insurance or welfare plan identification card
- A student identification card
- A utility bill
- Federal or state income tax forms
- An unemployment benefits statement
- If the identification items listed above are not available, hospital staff may request one of the following items:
    - A piece of mail addressed and delivered to the individual
    - A signed attestation from a third party
    - A signed statement from the individual

Any of the documents listed above may be used to prove New Jersey residency. Additionally, the hospital may accept an attestation from the individual that he or she is homeless.

Income verification may include any one of the following:

- Federal or state income tax returns
- Pay stubs
- W-2 forms
- A letter from an employer
- Annual Social Security benefits statement or copies of bank statements from three months prior that indicate direct deposit of a Social Security check
- If the documents listed above are not available, hospital staff may request an individual to attest to his or her income

Asset documentation includes:

- A statement from a bank or other applicable financial institution
- An attestation from the individual

The Maryland Hospital Association (MHA) voluntary guidelines for financial assistance state that "financial assistance will be provided to individuals and families who properly document eligibility." The guidelines do not provide specific documents.

Community Catalyst, a patient advocacy organization, recommends that documentation requirements not create a barrier to free care. Community Catalyst states that hospitals should accept an affidavit from the patient if no other documentation is available.

Taking these policies and the deliberations of the Work Group into account, the following provisions regarding Miscellaneous Policies and Reporting Requirements are recommended:

Recommendations on Miscellaneous Policies and Reporting Requirements

1. Hospitals may require from patients or their guarantors only those documents required to validate information provided on the Maryland State Uniform Financial Assistance Application. The documentation requirements do not apply to patients who are presumptively eligible.
2. All financial assistance and credit and collections policies must be reviewed and approved by the hospital's board of directors every 3 years. Any policy changes shall not be effective without Board approval.
3. The workgroup encourages refinement to, and the proliferation of, One-E-App on a statewide basis.
4. The report currently required to be submitted to the HSCRC within 30 days of a hospital's fiscal year end under COMAR10.37.10.26 shall include:
    - Name(s) of any collection agent(s) used;
    - Hospital processes and policies for assigning a debt to a collection agent and for compensating such collection agent for services rendered;
        i. The number of liens placed;
        ii. The number of extended payment plans exceeding 5 years established with patients during the year;
        iii. The documentation requirements utilized by the hospital for individuals to qualify for financial assistance; and
        iv. Whether the Board of Directors of the hospital receives a report on:
            1. The number of accounts reported to credit reporting agencies;
            2. The number of accounts where wage garnishment was imposed;
            3. The number of accounts where a lien was placed on a patient's primary residence or motor vehicle; and
            4. The number of accounts where legal action was taken.

Changes to Handling Charity Care in the Uncompensated Care Provision

Chapters 310 and 311 require the Commission to study and make recommendations on incentives for hospitals to provide free and reduced-cost care to patients without the means to pay their hospital bills and to report to the Governor and the General Assembly on or before October 1. 2009.

The Commission's uncompensated care methodology currently does not distinguish between bad debt and charity care. As a result, the Commission has found some inconsistency in reporting bad debt and charity care. The Commission has worked with hospital representatives in refining an

alternative methodology that would reward those providing a greater proportion of charity care. The proposal detailed below was presented to the Commission as a draft recommendation during the Commission meeting held on September 2, 2009. Staff intends to present a final recommendation on October 14, 2009.

The existing uncompensated care methodology is used to determine the amount of bad debt that should be included in hospital rates through a mark-up on hospital rates. At the core of the policy is a regression equation that is used to determine the expected level of uncompensated care for each hospital based on the mix of patients at the hospital. The methodology also factors in the actual uncompensated care provided at the hospital during the past three years.

Recommendation on Handling Charity Care in the Uncompensated Care Policy

The Commission recommends continuing the current methodology but to adjust the amount of charity care by a reasonable percentage (examples have used 20%). The value of charity care in the policy, therefore, will be inflated by 20%, for example. The total amount of uncompensated care would then be neutralized so it would be revenue neutral to the system. Those hospitals with a greater proportion of charity care would obtain a higher uncompensated care policy result, thereby allowing for an increase in their rates to cover those costs. The draft recommendation and modeling using existing charity care data to calculate a result using a 20% charity care incentive can be found in Appendix VII.

V. Summary of Findings and Recommendations

Findings and Observations

After reviewing financial assistance and collection policies in Maryland and other states as well as stakeholders' guidelines, it is clear that there is some need to create standards of best practice. However, these standards should not preclude some degree of flexibility. Maryland hospitals have demonstrated an ability and willingness on many occasions to go beyond the standards of their own policies to provide financial assistance and payment plans to uninsured and underinsured patients. Generally, hospitals recognize the costs in time and money to attempt to collect the full amount from patients who are unable to pay their bills. Studies have shown that reduced cost care policies and payment plans can yield higher recoveries than instituting judgments and liens. Further, prudent efforts to gather information from patients in an appropriate manner can also qualify patients for Medicaid or other public program, providing full coverage for patients without the means to pay their bills.

The culmination of Work Group deliberations and the results of the Commission's February 2009 review have revealed that voluntary policies of Maryland hospitals, as well as requirements set forth in state law and regulation, have placed Maryland among the most progressive states in financial assistance and debt collection. Still, HSCRC surveys and the February 2009 review illustrate that variation exists in policies and procedures, and instances do occur where patients can "fall through the cracks." The HSCRC believes that is it not the intent of hospitals, in any way, to cause financial or emotional hardship for individuals who are infirm or indigent and who could quality (under a reasonable set of industry-wide criteria) for financial assistance and charity care. Reasonable best practice standards as proposed in this report can benefit hospitals and patients alike.

The HSCRC staff believes that the recommendations of this report meet the delicate balance of protecting uninsured and underinsured patients from being saddled with hospital bills that are beyond their means to pay while at the same time allowing flexibility for hospitals to continue to provide further assistance to patients as they have done in the past. As such, we believe the recommendations best reflect the interests of the broader public (both stakeholders and Maryland citizens).

The HSCRC and the staff would like to thank the participants in the Work Group discussions for addressing many pertinent issues in a short period time. All parties provided informed input which helped to shape these recommendations.

Recommendations

The recommendations below are divided into five sections: financial assistance policies, collection policies, miscellaneous policies, reporting requirements, and specialty hospitals. They represent the recommendations of the HSCRC based on the discussions of the Work Group on each of the identified issues. Also included are the comments of representatives of the work group on various

recommendations. Comment letters from Work Group members can be found in Appendix VIII. Some recommendations, as indicates, require legislative changes, while others may be accomplished through a regulatory or policy change.

The following guiding principles were used by the HSCRC and the Workgroup as criteria/rationales in arriving at these recommendations:

- Maryland hospitals support access to medically necessary care for all patients, regardless of financial means.
- Maryland's unique rate-setting system provides hospitals with protection for the provision of virtually all uncompensated care.
- Financial Assistance (charity care) is more appropriate than bad debt (and its associated collections processes) for patients who cannot afford their hospital bills. While the financial impact of write-offs on hospitals currently is the same, financial assistance is less stressful on patients and it avoids administrative procedures that can ultimately prove unfruitful.
- Some level of uniformity in financial assistance and collection policies is appropriate to create a statewide floor.
- Some measure of flexibility in these policies is necessary to reflect varying socioeconomic differences in the hospitals' service areas and patient mix.
- The potential impact on a hospital's financial condition must be considered.
- Fairness to patients, purchasers, and payers of hospital care is the objective.
- The administrative burden associated with the policies must be manageable (for hospitals, patients, HSCRC, and other parties).
- Maryland has been among the most progressive states in adopting laws, regulations, and voluntary guidelines relating to hospital financial assistance and collection policies. Maryland should continue to innovate in this area.
- Accountability on the part of the hospital in balancing the needs of patients with hospital financial factors, as well as on the part of patients to provide adequate documentation in a timely manner is required.

I. Financial Assistance Policies

A. Free Care

1. Free care shall be available to uninsured patients who otherwise are not eligible for public insurance with gross household income up to at least 200 percent of the federal poverty level [This would require a change in regulation].

    - **Household** is defined as the patient, the patient's spouse living in the household, and all of the patient's dependents who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), anyone claiming the patient as a dependent, and the parent's other dependents who live in the patient's home.

- **Gross Household income** is defined as a household's total income from all sources, including, without limitation, gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, family-owned business interests, royalties, estates, trust funds, child support, and alimony.

2. Hospitals can request a lower standard (no lower than 150 percent of the FPL), but must demonstrate to the HSCRC that a standard of 200 percent of FPL would yield undue financial hardship to the hospital [This would require a regulatory change].

3. If a hospital has collected more than $25 from a patient (or the patient's guarantor) who, within a 2-year period after the date of service, was found to be eligible for free care on the date of service, the hospital must refund to the patient (or the patient's guarantor) the amount collected above $25 [This would require a legislative change]. Likewise, if a judgment or adverse credit report has been entered on a patient who was later found to be eligible for free care on the date of service, the judgment or adverse credit report shall be vacated and stricken.

    - This policy excludes patients with a means-tested government health care plan that requires the patient to pay out-of-pocket for selected healthcare services.
    - This policy is predicated on the patient complying with his/her responsibilities under Section I.G. of these recommendations.
    - The 2-year period under this policy may be reduced to no less than 30 days after the hospital requests relevant information from the patient in order to make a determination of eligibility for financial assistance, if documentation exists of the patient's (or the guarantor's) unwillingness or refusal to provide documentation, or the patient is otherwise uncooperative regarding his/her patient responsibilities.

Comments of Hospital Representatives: 200% threshold (#1) is too high for an industry-wide standard. Current law is 150% of FPL. The Standard should be 150%, and HSCRC should consider higher standard on a hospital-by-hospital basis. 200% is inconsistent with current language and intent of Maryland law.

Comments of Hospital Representatives: The period to determine eligibility for which a refund may apply (#3) is too long – The Medicaid period is 90 days. Since Medicaid has determined that 90 days is an appropriate period of time for eligibility, it should apply to refunds as well.

Comments of Legal Aid: The period to determine eligibility for which a refund may apply (#3) is too short – Maryland contractual statute of limitations is 3 years.

ents of the following means-tested social services programs are deemed eligible for free care, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days [these recommendations could be accomplished through a regulatory change]:

- Households with children in the free or reduced lunch program

- Supplemental Nutritional Assistance Program (SNAP)
- Low-income household energy assistance program
- Primary Adult Care Program (PAC) (until such time as inpatient benefits are added to the PAC benefit package)
- Women, Infants & Children (WIC)

2. The HSCRC may specify through regulation that patients who are beneficiaries/recipients of additional means-tested social services programs are eligible for free care as appropriate [regulatory change].
3. Hospitals may use additional presumptive eligibility criteria to deem patients eligible for free care.

Comments from Legal Aid Bureau: Time period for submission of documentation of proof of enrollment in an eligible program should be flexible to account for circumstances when patients cannot readily access such documentation.

C. Reduced Cost Care for Medically Necessary Services

1. Discounts shall be available to uninsured patients with household income up to at least 300 percent of the FPL [regulation change].
2. Hospitals can request a lower standard for reduced cost care, but must demonstrate to the HSCRC that a standard of 300 percent of FPL would yield undue financial hardship to the hospital [regulation change].
3. The maximum patient payment for reduced-cost care shall not exceed the charges minus hospital's aggregate markup [regulation change].

D. Medical Hardship (Medical Indigence)

1. Medical debt for out-of-pocket expenses (excluding copays, deductibles, and coinsurance) for uninsured or underinsured patients (incurred over a 12-month period) cannot exceed 25% of household income [legislative change]. For example, if one or more patients in a household earning $60,000 per year receive hospital bills in the amount of $40,000, the maximum out-of-pocket medical debt for non-covered medically necessary services is $15,000, less any applicable copays, deductibles, and coinsurance (25 percent of $60,000), and $25,000 must be written-off as charity care. Any payment plan for the patients in this household would be premised on the $15,000 in household out-of-pocket debt. To be eligible to have this maximum amount applied to subsequent charges, the patients shall inform the hospital in subsequent admissions or outpatient encounters that one or more

members of the household has previously received health care services from that hospital and was determined to be entitled to the discount.

- Medical debt includes all medical costs (excluding copays, deductibles, and coinsurance) for which the hospital billing office is responsible to bill. Therefore, if a hospital does not bill for physician services, physician costs may be excluded by the hospital when calculating the medical debt.

- Hospitals may adopt policies to exclude a patient from the application of the medical hardship policy when the patient has income that exceeds 500% of FPL.

- For patients whose household income falls in the income range between 200% and 300% of FPL, if the medical hardship policy would result in a more patient-friendly reduction than the reduced cost policy (found above), the medical hardship policy would apply.

- When distributing amounts collected from patients under this section between the hospital and physician(s) (for medical costs that the hospital billing office is responsible for billing), the hospital shall not distribute to the physician an amount greater than:

    - For an insured patient, the amount paid by the patient's insurer; or

    - For an uninsured patient, what would otherwise be paid to the physician under the Medicare fee schedule for the services provided.

- Comments from Hospital Representatives: Because of many variables (size of bill related to income, ability to pay, median income for service area, ongoing medical expenses, family size, etc.), it is inappropriate to establish one standard, but all hospitals should be required to develop a policy for medical hardship.

E. Assets

1. A hospital may, in its discretion, consider household monetary assets in determining eligibility for financial assistance in addition to the income-based criteria, or it may choose to use only income-based criteria [regulation change]. If a hospital chooses to utilize an asset test, that test must adhere to the following bulleted items:

    - "Monetary assets" are those assets that are convertible to cash excluding a primary residence, and retirement assets, which are defined to be those assets (such as a 401K) where the IRS has granted preferential tax treatment as a retirement account including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans.
    - A principal residence may be considered in making a financial assistance determination after first excluding a "safe harbor" equity in the home in the amount of $150,000.
    - At a minimum, the first $10,000 of monetary assets may not be considered when determining eligibility for free or reduced cost care.

Comments of Legal Aid Bureau: A principal residence should be completely excluded from asset consideration.

Comments of Legal Aid Bureau: Only the enumerated assets should be counted.

Comments of Hospital Representatives: Treating certain types of income differently could lead to unintended inequities, e.g., a 60 year old with sufficient retirement funds to retire early compared with a an individual with no retirement benefits who continues to work.

F. Documentation Requirements

1. Hospitals may require from patients or their guarantors only those documents required to validate information provided on the Maryland State Uniform Financial Assistance Application [regulation].
2. The documentation requirements do not apply to patients who are presumptively eligible under Section I. B. of these recommendations.

Comments of Legal Aid Bureau: Documentation requirements (#1) should be further limited to specific information during a specified period of time.

G. Patient Responsibilities

1. The following patient responsibilities will be added to the HSCRC's guidelines for the Information Sheet [guideline or regulation change]:

    - To receive financial assistance benefits, a patient responsible for paying a hospital bill must act reasonably and cooperate in good faith with the hospital by providing the hospital and any third party agents with which the hospital has a valid collection agreement with all of the reasonably requested financial and other relevant information and documentation needed to determine the patient's eligibility under the hospital's financial assistance policy. Hospitals should provide reasonable payment plan options to qualified patients within 30 days of a request for such information.
    - A patient responsible for paying a hospital bill shall communicate to the hospital and any third party agents with which the hospital has a valid collection agreement any material change in the patient's financial situation that may affect the patient's ability to abide by the provisions of an agreed upon reasonable payment plan or qualification for financial assistance within 10 days of the change.
    - To receive financial assistance, an uninsured patient may be required by the hospital first to apply for coverage under public programs (such as Medicare, Medicaid, State

Children's Health Insurance Program or other programs) if there is reasonable basis to believe that the uninsured patient may be eligible for such program.

Comments of Legal Aid Bureau: An extension of the 30 day documentation submission period should be specifically permitted if "good cause" exists.

H. Patient Education and Outreach

1. The information sheet and posted notice to patients shall include information on patients' rights to apply for financial assistance and contact information [legislative change].

2. A hospital must post conspicuous notices of its financial assistance policy in the billing office, inpatient and outpatient admitting/registration, and emergency department. Current law requires that these postings "describe the financial assistance policy." This shall be interpreted to mean "to notify patients of the availability of financial assistance programs" [regulation change].
3. The posted notice must be reasonably legible, no smaller than 8.5 by 11 inches, and in languages spoken by any limited English proficient population that constitutes at least 20% of the a hospital's service area [regulation change].
4. The hospital must provide interpreter services in languages spoken by any limited English proficient population that constitutes at least three percent of a hospital's service area population to assist those patients with financial assistance and billing questions [regulation change].
5. The information sheet shall also be available in languages spoken by any limited English proficient population that constitutes at least three percent of a hospital's service area population [guideline or regulation change].

Comments of Legal Aid Bureau: Hospitals should voluntary provide consumers with information on what may occur if they do not pursue financial assistance options or do not pay their bills.

Comments of Hospital Representatives: Current uniform financial assistance application, patient information sheet, reporting regulations, and special audits are sufficient.

II. Collection Policies

1. Upon request, the hospital shall provide the patient with a written estimate of the total charges for the hospital services, procedures, or supplies that are reasonably expected to be

provided and billed to the patient by the hospital [legislative change]. It shall be clearly stated that this is an estimate and that actual charges could vary. The hospital may provide this estimate during normal business office hours. This section shall not apply to emergency services provided to a patient.

2. A hospital shall provide patients with clear information (including on all bills) on how to contact the hospital to inquire or to dispute a bill and shall respond to patients' inquiries within 30 days. The hospital shall make this information available in all of the languages for which the hospital provides onsite interpreter services (limited English proficient population that constitutes at least 3% of the hospital's service area) [regulation change].

3. For an uninsured patient, or for a patient that provides information that he or she may be a patient with high medical costs, a hospital or any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 120 days after the first initial patient bill (excluding the Maryland summary statement) unless documentation exists of the patient's (or the guarantor's) unwillingness or refusal to pay, or the patient is uncooperative with patient responsibilities [law change].
    - Unless documentation exists of the patient's (or the guarantor's) unwillingness or refusal to pay or the patient is uncooperative with patient responsibilities, the hospital or the hospital's contracted third party shall continue to work with patients to resolve billing issues including entering into payment plans.
4. Hospitals' credit and collection policies shall provide detailed procedures for the following actions [regulation change]:
    - When a patient debt may be reported to a credit reporting agency (in compliance with #3 above);
    - When legal action may commence regarding a patient debt (in compliance with #3 above);
    - When garnishments may be applied to a patient's or patient guarantor's income; and
    - When a lien on a patient's or a patient guarantor's personal residence or motor vehicle may be placed.
5. If a hospital delegates collection activity to an outside collection agency, it shall do so by means of an explicit authorization or contract to do so and shall require that the third party agree to abide by the hospital's credit and collection policies. The hospital shall specify procedures the collection agency will follow if patients appear to qualify for financial assistance [law change].

6. Hospitals shall assure that third party collection agents will provide the patient with an opportunity to file a grievance or complaint and will forward all grievances or complaints to the hospital regarding the bill or the conduct of the collection agent [law change].

7. Hospitals and their third party collection agents shall remove relevant patient debt items from the patient's credit report once that debt is paid in full [law change].

8. There should not be any change to the pre-judgment or post-judgment interest rules or rates.

9. Under current law, it is permissible for a hospital to secure a lien on a principal residence. The hospital shall not permit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical debt. Provided a hospital timely records any lien on a principal residence, a hospital shall maintain the right to defend its legal position as a secured creditor with respect to other creditors to whom the patient may owe a debt [Clarifying change in law].

Comments of Legal Aid Bureau: Hospital Board of Directors should review and approve collection policies annually or bi-annually and receive information on liens, garnishments and judgments.

Comments of Legal Aid Bureau: Patient accounts should not be assigned to a collection agency until 120 days after the date of service unless the patient has acted in bad faith on more than 2 occasions in the past.

1. All financial assistance and credit and collections policies must be reviewed and approved by the hospital's Board of Directors every 3 years [law change]. Any policy changes shall not be effective without Board approval.
2. Hospitals shall offer uninsured patients with income between 200 percent and 500 percent of the FPL that request assistance the opportunity to enter into a payment plan for their hospital care, and the period of time and monthly payments for this payment plan must be reasonable. Any extended payment plans offered by a hospital to assist patients eligible under the hospital's financial assistance policy shall be interest free [regulation change].
3. Hospitals shall provide a mechanism whereby patients may have hospital decisions regarding the granting of financial assistance and the establishment of payment plans reconsidered [regulation change].
4. The workgroup encourages the refinement and proliferation of One-E-App on a statewide basis.

Comments from Hospital Representatives: The request for a payment plan (#2) should be documented with a signature from the patient. Applicants need to be responsible and apply.

Comments from Legal Aid Bureau: If documentation and signature are required to request a payment plan (#2), the form should be short and simple.

IV. Reporting Requirements

The report currently required to be submitted to the HSCRC within 30 days of hospitals' fiscal year end under COMAR10.37.10.26 shall include [regulation change]:

1. Name(s) of any collection agent(s) used;

2. Hospital processes and policies for assigning a debt to a collection agent and for compensating such collection agent for services rendered;

3. The number of liens placed on residences;

4. The number of extended payment plans exceeding 5 years established with patients during the year;

5. The documentation requirements utilized by the hospital for individuals to qualify for financial assistance; and

6. Whether the Board of Directors of the hospital receives a report on:

    - The number of accounts reported to credit reporting agencies;
    - The number of accounts where wage garnishment was imposed;
    - The number of accounts where a lien was placed on a patient's primary residence or motor vehicle; and
    - The number of accounts where legal action was taken.

Comments of Hospital Representatives: Recommendation adds yet another layer of detailed reporting that is of questionable need or value.

Comments of Office of Attorney General, Health and Education Advocacy Unit: Rather than reporting to HSCRC on whether Hospital Boards receive a report, each hospital should report on the number of accounts: (1) reported to credit reporting agencies, (2) where garnishments were imposed, (3) which liens were placed, and (4) where legal action was taken.

V. Special Treatment of Private Psychiatric and Chronic Care Hospitals

1. The recommendations of this report shall apply to Maryland's Chronic Care Hospitals.
2. Financial assistance and collection policy recommendations should be deferred for private psychiatric hospitals.

VI. Establishing Incentives for Charity Care in the Uncompensated Care Policy

1. The Commission recommends continuing its current uncompensated care methodology but adjusting the amount of charity care by a reasonable percentage (examples have used 20%). The value of charity care in the policy, therefore, will be inflated by 20%, for example. The total amount of uncompensated care would then be neutralized so it would be revenue neutral to the system. Those hospitals with a greater proportion of charity care would obtain a higher uncompensated care policy result, thereby allowing for an increase in their rates to cover those costs [HSCRC policy change].

Appendices

Appendix I

CHAPTER 311

(House Bill 1069)

AN ACT concerning

Health Services Cost Review Commission – Financial Assistance and Debt Collection Policies

FOR the purpose of requiring ~~each hospital~~ the Health Services Cost Review Commission to require certain hospitals in the State to develop a financial assistance policy for providing free care and reduced–cost care to certain patients; requiring a hospital to post a certain notice in its billing office; requiring each hospital to develop an information sheet that meets certain requirements; requiring the ~~Health Services Cost Review~~ Commission to establish uniform requirements for the information sheet and review each hospital's implementation of and compliance with certain requirements; requiring each hospital to ensure the availability of staff with certain training; altering requirements for each hospital's submission of a policy on debt collection; requiring the policy to meet certain requirements; requiring the Commission to review each hospital's implementation of and compliance with the policy and requirements; authorizing the Commission to impose a certain fine under certain circumstances and to consider certain items before imposing a fine; altering the requirements for regulations establishing alternative methods for financing certain costs of care; requiring the Commission to establish a workgroup on patient financial assistance and debt collection for ~~a certain purpose~~ certain purposes; requiring the workgroup to report certain findings and recommendations on or before a certain date; requiring the Commission to study, make recommendations, and report on incentives for hospitals to provide free and reduced–cost care to certain patients; ~~requiring the Office of the Attorney General, in consultation with certain entities and persons, to study, make recommendations, and report on the use of liens and the legal rate of interest on judgments for certain hospital bills;~~ and generally relating to the Health Services Cost Review Commission and hospital financial assistance and debt collection policies.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214(b) and 19–214.1
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY adding to
Article – Health – General
Section 19–214.2 and 19–214.3

Annotated Code of Maryland
(2005 Replacement Volume and 2008 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.

(b) The Commission may adopt regulations establishing alternative methods for financing the reasonable total costs of hospital uncompensated care provided that the alternative methods:

(1) Are in the public interest;

(2) Will equitably distribute the reasonable costs of uncompensated care;

(3) Will fairly determine the cost of reasonable uncompensated care included in hospital rates;

(4) Will continue incentives for hospitals to adopt **FAIR,** efficient, and effective credit and collection policies; and

(5) Will not result in significantly increasing costs to Medicare or the loss of Maryland's Medicare Waiver under § 1814(b) of the Social Security Act.

19–214.1.

~~(a) Each hospital in the State shall develop a financial assistance policy for providing [free and reduced–cost care to low–income] TO patients who lack health care coverage OR WHOSE HEALTH CARE COVERAGE DOES NOT PAY THE FULL COST OF THE HOSPITAL BILL.~~

(A) (1) THE COMMISSION SHALL REQUIRE EACH ACUTE CARE HOSPITAL IN THE STATE 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:

~~(1)~~ (I) **FREE MEDICALLY NECESSARY CARE TO PATIENTS WITH FAMILY INCOME AT OR BELOW 150% OF THE FEDERAL POVERTY LEVEL; AND**

~~(2)~~ (II) **REDUCED–COST MEDICALLY NECESSARY CARE TO LOW–INCOME PATIENTS WITH FAMILY INCOME ABOVE 150% OF THE FEDERAL POVERTY LEVEL, IN ACCORDANCE WITH THE MISSION AND SERVICE AREA OF THE HOSPITAL.**

(3) *(I)* THE COMMISSION BY REGULATION MAY ESTABLISH INCOME THRESHOLDS HIGHER THAN THOSE UNDER PARAGRAPH (2) OF THIS SUBSECTION.

(II) IN ESTABLISHING INCOME THRESHOLDS THAT ARE HIGHER THAN THOSE UNDER PARAGRAPH (2) OF THIS SUBSECTION FOR A HOSPITAL, THE COMMISSION SHALL TAKE INTO ACCOUNT:

1. THE PATIENT MIX OF THE HOSPITAL;

2. THE FINANCIAL CONDITION OF THE HOSPITAL;

3. THE LEVEL OF BAD DEBT EXPERIENCED BY THE HOSPITAL; AND

4. THE AMOUNT OF CHARITY CARE PROVIDED BY THE HOSPITAL.

(b) A hospital shall post a notice in conspicuous places throughout the hospital, **INCLUDING THE BILLING OFFICE,** describing the financial assistance policy and how to apply for free and reduced–cost care.

(c) The Commission shall:

(1) Develop a uniform financial assistance application; and

(2) Require each hospital to use the uniform financial assistance application to determine eligibility for free and reduced–cost care under the hospital's financial assistance policy.

(d) The uniform financial assistance application:

(1) Shall be written in simplified language; and

(2) May not require documentation that presents an undue barrier to a patient's receipt of financial assistance.

(e) **(1)** Each hospital shall [establish a mechanism to provide the uniform financial assistance application to patients who do not indicate public or private health care coverage] **DEVELOP AN INFORMATION SHEET THAT:**

(I) DESCRIBES THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY;

(II) DESCRIBES A PATIENT'S RIGHTS AND OBLIGATIONS WITH REGARD TO HOSPITAL BILLING AND COLLECTION UNDER THE LAW;

(III) PROVIDES CONTACT INFORMATION FOR THE INDIVIDUAL OR OFFICE AT THE HOSPITAL THAT IS AVAILABLE TO ASSIST THE PATIENT, THE PATIENT'S FAMILY, OR THE PATIENT'S AUTHORIZED REPRESENTATIVE IN ORDER TO UNDERSTAND:

1. THE PATIENT'S HOSPITAL BILL;

2. THE PATIENT'S RIGHTS AND OBLIGATIONS WITH REGARD TO THE HOSPITAL BILL;

3. HOW TO APPLY FOR FREE AND REDUCED–COST CARE; AND

4. HOW TO APPLY FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND ANY OTHER PROGRAMS THAT MAY HELP PAY THE BILL;

(IV) PROVIDES CONTACT INFORMATION FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM; AND

(V) INCLUDES A STATEMENT THAT PHYSICIAN CHARGES ARE NOT INCLUDED IN THE HOSPITAL BILL AND ARE BILLED SEPARATELY.

(2) THE INFORMATION SHEET SHALL BE PROVIDED TO THE PATIENT, THE PATIENT'S FAMILY, OR THE PATIENT'S AUTHORIZED REPRESENTATIVE:

(I) BEFORE DISCHARGE;

(II) WITH THE HOSPITAL BILL; AND

(III) ON REQUEST.

(3) THE HOSPITAL BILL SHALL INCLUDE A REFERENCE TO THE INFORMATION SHEET.

(4) THE COMMISSION SHALL:

(I) ESTABLISH UNIFORM REQUIREMENTS FOR THE INFORMATION SHEET; AND

(II) REVIEW EACH HOSPITAL'S IMPLEMENTATION OF AND COMPLIANCE WITH THE REQUIREMENTS OF THIS SUBSECTION.

[(f) (1) Each hospital shall submit to the Commission the hospital's policy on the collection of debts owed by patients who qualify for reduced–cost care under the hospital's financial assistance policy.

(2) On or before July 1, 2006, the Commission shall report, in accordance with § 2–1246 of the State Government Article, to the House Health and Government Operations Committee and the Senate Finance Committee on the details of the policies submitted to the Commission under paragraph (1) of this subsection.]

(F) EACH HOSPITAL SHALL ENSURE THE AVAILABILITY OF STAFF WHO ARE TRAINED TO WORK WITH THE PATIENT, THE PATIENT'S FAMILY, AND THE PATIENT'S AUTHORIZED REPRESENTATIVE IN ORDER TO UNDERSTAND:

(1) THE PATIENT'S HOSPITAL BILL;

(2) THE PATIENT'S RIGHTS AND OBLIGATIONS WITH REGARD TO THE HOSPITAL BILL;

(3) HOW TO APPLY FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND ANY OTHER PROGRAMS THAT MAY HELP PAY THE HOSPITAL BILL; AND

(4) HOW TO CONTACT THE HOSPITAL FOR ADDITIONAL ASSISTANCE.

19–214.2.

(A) EACH HOSPITAL SHALL SUBMIT TO THE COMMISSION, AT TIMES PRESCRIBED BY THE COMMISSION, THE HOSPITAL'S POLICY ON THE COLLECTION OF DEBTS OWED BY PATIENTS.

(B) THE POLICY SHALL:

(1) PROVIDE FOR ACTIVE OVERSIGHT BY THE HOSPITAL OF ANY CONTRACT FOR COLLECTION OF DEBTS ON BEHALF OF THE HOSPITAL;

(2) PROHIBIT THE HOSPITAL FROM SELLING ANY DEBT;

~~**(3) PROHIBIT THE HOSPITAL FROM PLACING A LIEN ON A PRIMARY RESIDENCE;**~~

~~(4)~~ (3) PROHIBIT THE CHARGING OF INTEREST ON ~~OVERDUE BILLS~~ BILLS INCURRED BY SELF–PAY PATIENTS BEFORE A COURT JUDGMENT IS OBTAINED;

~~(5)~~ (4) DESCRIBE IN DETAIL THE CONSIDERATION BY THE HOSPITAL OF PATIENT INCOME, ASSETS, AND OTHER CRITERIA;

~~(6)~~ (5) DESCRIBE THE HOSPITAL'S PROCEDURES FOR COLLECTING A DEBT; AND

~~(7)~~ (6) DESCRIBE THE CIRCUMSTANCES IN WHICH THE HOSPITAL WILL SEEK A JUDGMENT AGAINST A PATIENT.

(C) THE COMMISSION SHALL REVIEW EACH HOSPITAL'S IMPLEMENTATION OF AND COMPLIANCE WITH THE HOSPITAL'S POLICY AND THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION.

19–214.3.

(A) IF A HOSPITAL KNOWINGLY VIOLATES ANY PROVISION OF § 19–214.1 OR § 19–214.2 OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER THIS SUBTITLE, THE COMMISSION MAY IMPOSE A FINE NOT TO EXCEED $50,000 PER VIOLATION.

(B) BEFORE IMPOSING A FINE, THE COMMISSION SHALL CONSIDER THE APPROPRIATENESS OF THE FINE IN RELATION TO THE SEVERITY OF THE VIOLATION.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall establish a workgroup on patient financial assistance and debt collection. The workgroup shall review:

(1) the need for uniform policies among hospitals relating to patient financial assistance and debt ~~collection and shall consider the following elements for inclusion in~~ collection, including as elements within any uniform policies:

~~(1)~~ (i) income thresholds and any special treatment of disability and pension income;

~~(2)~~ (ii) asset thresholds and treatment of various types of assets;

(iii) use of liens to enforce collection of a debt;

~~(3)~~ (iv) collection procedures;

~~(4)~~ (v) establishment of guardianship;

~~(5)~~ (vi) use of judgments to collect debts; and

~~(6)~~ (vii) patient education and outreach to inform patients of the availability of financial assistance with their bills;

(2) the desirability of applying any uniform policies to private psychiatric and chronic care hospitals; and

(3) the desirability of altering the legal rate of interest on a judgment to collect a hospital debt.

(b) The workgroup shall report its findings and recommendations, including recommendations for legislation, to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on or before October 1, 2009.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall study and make recommendations on incentives for hospitals to provide free and reduced–cost care to patients without the means to pay their hospital bills.

(b) The Commission shall report its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on or before October 1, 2009.

~~SECTION 4. AND BE IT FURTHER ENACTED, That:~~

~~(a) The Office of the Attorney General, in consultation with the American Bar Association, Legal Aid, the University of Maryland Law School, and other interested persons, shall study and make recommendations on the use of liens and the legal rate of interest on a judgment for a hospital bill of a patient without health~~

~~insurance. The study shall take into account the use of liens and the legal rate of interest on other types of debt.~~

~~(b) The Judiciary shall report its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on or before October 1, 2009.~~

~~SECTION 5. AND BE IT FURTHER ENACTED, That~~ this Act shall take effect June 1, 2009.

Approved by the Governor, May 7, 2009.

Appendix II

Appendix II

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
AREA CODE 410-764-2605
FAX 410-358-6217
Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

To: All CFOs Maryland Acute Care Hospitals

From: Robert Murray, Executive Director

Date: May 21, 2009

Re: Maryland Hospital Patient Information Sheet

According to Health-General §19-214.1(e), Maryland's acute care hospitals must provide a patient information sheet to patients being discharged from the hospital. The HSCRC has developed guidelines for assisting hospitals in developing their patient information sheet. The requirement has a June 1, 2009 effective date, which all acute hospitals must be prepared to meet.

In order to fulfill the requirements of the statute, the HSCRC will require that all acute care hospitals provide a copy of their information sheet to the HSCRC by June 19, 2009. It should be sent to Amanda Greene at the following email address: agreene@hscrc.state.md.us .

If you have any questions regarding the enclosed information, please contact Steve Ports or Amanda Greene at 410-764-2605.

HSCRC Guidelines for Developing the Maryland Hospital Patient Information Sheet

A patient information sheet is required to be provided to patients and their representatives at discharge, with hospital bills, and on request

Hospital Financial Assistance Policy: (This is intended to inform patients about the hospital's financial assistance policy. Give a 3 – 10 line description)

Example:

- This hospital provides emergency or urgent care to all patients regardless of ability to pay.
- You are receiving this information sheet because under Maryland law, this hospital must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance with the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you are low-income.
- This hospital meets or exceeds the legal requirement by providing financial assistance based on: (give specifics of your financial assistance policy for free or reduced-cost care; i.e. income level, family size, etc., stress the importance of collecting correct information).

Patients' Rights and Obligations

Patients' Rights: (This section is intended to inform patients of their right to receive assistance in paying their hospital bills)

Example:

- Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.
- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance (see contact information below).
- You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the state and federal governments that pays the full

cost of health coverage for low-income individuals who meet certain criteria (see contact information below).

Patients' Obligations: (This section is intended to inform patients of their obligation to pay the hospital bill and to provide complete and accurate information to the hospital)

Example:

- For those patients with the ability to pay their bill, it is the obligation of the patient to pay the hospital in a timely manner.
- This hospital makes every effort to see that patient accounts are properly billed, and patients may expect to receive a uniform summary statement within 30 days of discharge. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office promptly, (give phone number) to discuss this matter.
- If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts: (this section is intended to provide easy access for patients to contact the hospital, Medical Assistance, etc.)

Example:

- If you have questions about your bill, please contact the hospital business office at: (give phone number.) A hospital representative will be glad to assist you with any questions you may have.
- If you wish to get more information about or apply for the hospital's financial assistance plan, you may call (give phone number) or download the uniform financial assistance application from the following link: http://www.hscrc.state.md.us/consumers_uniform.cfm

- If you wish to get more information about or apply for Maryland Medical Assistance you may contact your local Department of Social Services by phone 1-800-332-6347; TTY: 1-800-925-4434; or internet www.dhr.state.md.us .

Physician Services

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement.

Maryland Hospital Patient Information Sheet

Frequently Asked Questions

1. **What must be provided to patients in the information sheet by acute care hospitals required under Health-General §19-214.1(e) and Maryland regulations, COMAR 10.37.10.26 (6)?**

    a. Description of the hospital's financial assistance policy;

    b. Description of the patient's rights and obligations with regard to hospital billing and collection under the law;

    c. Contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative with

        i. the patient's hospital bill;

        ii. the patient's rights and obligations; and

        iii. how to apply for free and reduced care.

    d. Contact information for the Maryland Medical Assistance Program; and

    e. A statement that physician charges are not included in the hospital bill and are billed separately.

2. **When must this sheet be available?**

    a. June 1, 2009, it must be ready to give to patients before discharge, along with the hospital bill, and upon request.

        i. Before discharge means the form can be provided to patients as part of the registration packet.

3. **Does the form have to be provided with every billing statement mailed to the patient?**

    a. It is the current position of the HSCRC that the information sheet be provided, at a minimum, with the initial bill; however, this position is subject to further review. If this position changes, hospitals will be given advance notice of any such change.

4. **Does the information sheet requirement apply only to bills for inpatient services?**

a. Yes. At this time, it refers to inpatient services. The Commission will study the feasibility of applying this requirement to outpatient bills as well. If this policy changes, hospitals will be given advance notice. The Commission expects that hospitals that have been providing an information sheet to patients receiving outpatient services in the past should continue to do so.

b. An information sheet is not required to be used by non-acute care, psychiatric and chronic care hospitals at this time. The Commission will be studying whether an information sheet should be provided by these facilities in the future.

5. **Do our patient information sheets have to be identical to the one developed by the HSCRC?**

   a. No. The HSCRC information sheet is a sample sheet designed to assist hospitals in understanding the elements that should be included. It is incumbent on hospitals to comply with the provisions specified under Question #1.

   b. The HSCRC will be requiring hospitals to submit their information sheets in place in mid-June (2009). The HSCRC will review these sheets for compliance with the law, commonality, and reasonableness. Following this review, the Commission may provide more specific requirements. Hospitals will be provided advance notice of any changes.

6. **Is a verification of receipt (patient signoff) necessary?**

   a. At this time, it will not be required. The HSCRC will consider this as part of the review referred to under Question #5b.

7. **In what language must the form be provided?**

   a. At a minimum, English and Spanish.

Appendix III

Appendix III

Financial Assistance and Debt Collection Policies Workgroup

Roster of Members

Louise Carwell – Legal Aid Bureau

Hal Cohen – CareFirst

John Folkemer - DHMH

William Foster – St. Agnes Hospital

Stephanie Garrity/Peter Beilenson – County Health Officer

Ray Grahe – Washington County Health System

Nelson Haller – Johns Hopkins Hospital

Donna Jacobs – University of Maryland

Paul Nicholson – Adventist Health Care

Pegeen Townsend – Maryland Hospital Association

Susan Whitecotton – MedStar Health

Ron Wineholt – Maryland Chamber of Commerce

Appendix IV

Appendix IV

Maryland Hospital Financial Assistance Policies

Provider Name	Prov. #	Notification Policy	No Pay Level	Full Pay Level	Asset Test	Who Signed	Catastrophic
MHA		Written in Eng & other lang; Posted or available at regist; or prior to sending bill to collection; Pub.ann in a paper or pub.forum	**150%**	**200%**	**Net assets <$10,000**		
MedStar							
FRANKLIN SQUARE	0015	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
GOOD SAMARITAN	2004	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
HARBOR HOSPITAL CTR.	0034	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
MONTGOMERY GENERAL	0018	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
UNION MEMORIAL	0024	MHA	200%	400%	$100,000 Net Worth	Not Stated	Yes
Hopkins							
HOWARD COUNTY	0048	MHA	150%	270%	Liquid Assets< $2,500	CFO/COO	Yes
JOHNS HOPKINS	0009	MHA	150%	270%	Liquid Assets< $2,500	CEO/Pres.	Yes
JOHNS HOPKINS / BAYVIEW	0029	MHA	150%	270%	Liquid Assets< $2,500	CEO/Pres.	Yes
Shore Health							
DORCHESTER GENERAL	0010	Not Stated	200%	300%	Not Stated	CFO/COO	Not Stated
MEMORIAL AT EASTON	0037	Not Stated	200%	300%	Not Stated	CFO/COO	Not Stated
WMHS							
MEMORIAL AT CUMBERLAND	0025	Not Stated	150%	200%	some real estate holdings	CFO/COO	Not Stated
SACRED HEART	0027	Not Stated	150%	200%	some real estate holdings	CFO/COO	Not Stated
Upper Chesapeake Health Systems							
HARFORD MEMORIAL	0006	Not Stated	150%	Not Stated	Liquid assets <$10,000	Director, PFS	Not Stated
UPPER CHESAPEAKE	0049	Not Stated	150%	Not Stated	Liquid assets <$10,000	Director, PFS	Not Stated
Dimensions Health							
GREATER LAUREL	0055	MHA	150%	300%	Net Assets <$10,000	CEO/Pres.	Yes
PRINCE GEORGE'S	0003	MHA	150%	300%	Net Assets <$10,000	CEO/Pres.	Yes
Adventist							
SHADY GROVE ADVENTIST	5050	MHA	100%	300%	Not Stated	Not Stated	Not Stated
WASHINGTON ADVENTIST	0016	MHA	100%	300%	Not Stated	Not Stated	Not Stated
Independents							
ANNE ARUNDEL	0023	MHA	200%	330%	Not Stated	Not Stated	Not Stated
ATLANTIC GENERAL	0061	Not Stated	200%	Not Stated	Not Stated	Director, PFS	Yes
BALTIMORE WASHINGTON	0043	MHA	200%	Not Stated	Not Stated	CFO/COO	Not Stated
BON SECOURS	0013	MHA	200%	Ability to	Not Stated	Board Chair	Yes
CALVERT MEMORIAL	0039	Exceeds MHA	175%	230%	Net Assets <$14,000	Board Chair	Yes
CARROLL COUNTY	0033	MHA	300%	375%	Not Stated	CFO/COO	Yes
CHESTER RIVER	0030	Not Stated	200%	Not Stated	Not Stated	CEO/Pres.	Not Stated
CIVISTA	0035	MHA	200%	300%	$7,500 Cash	Not Stated	Not Stated
DOCTORS	0051	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.	Not Stated
FORT WASHINGTON	0060	MHA	Not Stated	Not Stated	Not Stated	CEO/Pres.	Yes
FREDERICK MEMORIAL	0005	MHA	200%	300%	No Liquid	Director, PFS	Not Stated
G.B.M.C	0044	Not Stated	300%	Ability to	Liquid < $25,000	CFO/COO	Yes
GARRETT COUNTY	0017	MHA	150%	200%	Net Assets <$10,000	CFO/COO	Not Stated
HOLY CROSS	0004	Exceeds MHA	150%	300%	Assets<$10,000	Not Stated	Yes
KERNAN	2001	MHA	200%	Ability to	Assets<$10,000	CFO/COO	Yes
MARYLAND GENERAL	0038	MHA	150%	200%	Liquid < 100% FPL	CEO/Pres.	Not Stated
Mc CREADY	0045	Not Stated	150%	200%	Assets<$10,000	CEO/Pres.	Yes
MERCY	0008	MHA	200%	400%	Net Assets <$10,000	CFO/COO	Yes
NORTHWEST HOSPITAL	0040	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.	Not Stated
PENINSULA REGIONAL	0019	MHA	200%	200%	Assets<Account Balance	CEO/Pres.	Yes
SAINT AGNES	0011	Not Stated	200%	300%	Liquid assets <$10,000	CEO/Pres.	Yes
SAINT JOSEPH'S	0007	MHA	130%	195%	Not Stated	CFO/COO	Yes
SAINT MARY'S	0028	Exceeds MHA	Not Stated	Not Stated	Not Stated	CEO/Pres.	Not Stated
SINAI	0012	MHA	200%	Ability to	Not Stated	CFO/COO	Yes
SOUTHERN MARYLAND	0054	Not Stated	100%	Not Stated	Only primary resid.	Not Stated	Yes
SUBURBAN	0022	MHA	200%	200%	Not Stated	Not Stated	Yes
UNION OF CECIL	0032	Not Stated	150%	300%	Not Stated	CFO/COO	Not Stated
UNIVERSITY OF MD.	0002	MHA	200%	Ability to	Assets<$10,000	CFO/COO	Yes
WASHINGTON COUNTY	0001	MHA	150%	200%	Net Assets <$10,000	Director, PFS	Yes

Credit and Collection Policies - 2008

Provider Name	Prov. #	Days to Initiation of Collection	Interest	Pay-off period (Mos.)	Garnish Attach	Lien	Who Approved Policy
Medstar							
FRANKLIN SQUARE	0015	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
GOOD SAMARITAN	2004	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
HARBOR HOSPITAL CTR.	0034	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
MONTGOMERY GENERAL	0018	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
UNION MEMORIAL	0024	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
Hopkins							
HOWARD COUNTY	0048	90	Not Stated	18	Not Stated	Estate	CEO/Pres.
JOHNS HOPKINS	0009	90	Not Stated	18	Not Stated	Estate	CEO/Pres.
JOHNS HOPKINS / BAYVIEW	0029	90	Not Stated	18	Not Stated	Estate	CEO/Pres.
Shore Health							
DORCHESTER GENERAL	0010	90	Not Stated	6	Not Stated	Not Stated	Not Stated
MEMORIAL AT EASTON	0037	90	Not Stated	6	Not Stated	Not Stated	Not Stated
WMHS							
MEMORIAL AT CUMBERLAND	0025	90	Not Stated	Not Stated	Not Stated	Not Stated	CFO
SACRED HEART	0027	90	Not Stated	Not Stated	Not Stated	Not Stated	CFO
Upper Chesapeake Health Systen							
HARFORD MEMORIAL	0006	68	No interest	12	YES	NO	Director, PFS
UPPER CHESAPEAKE	0049	68	No interest	12	YES	NO	Director, PFS
Dimensions Health							
GREATER LAUREL	0055	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated	CFO
PRINCE GEORGE'S	0003	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated	CFO
Adventist							
SHADY GROVE ADVENTIST	5050	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
WASHINGTON ADVENTIST	0016	120	Not Stated	Not Stated	Not Stated	Not Stated	Director, PFS
Independents							
ANNE ARUNDEL	0023	90	No interest	Not Stated	Not Stated	Yes, Not primary res.	Not Stated
ATLANTIC GENERAL	0061	90	No interest	Not Stated	Not Stated	Not Stated	CFO
BALTIMORE WASHINGTON	0043	90	Not Stated	Not Stated	YES	YES	CFO
BON SECOURS	0013	Not Stated	If Bad Debt	8	Not Stated	NO	CFO
CALVERT MEMORIAL	0039	80	Not Stated	Not Stated	YES	YES	Board Chair
CARROLL COUNTY	0033	Not Stated	No interest	36	Not Stated	Not Stated	CFO
CHESTER RIVER	0030	60	Not Stated	Not Stated	Not Stated	Not Stated	CFO
CIVISTA	0035	60	Not Stated	Not Stated	YES	Not Stated	Director, PFS
DOCTORS	0051	120	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.
FORT WASHINGTON	0060	105	If Bad Debt	Not Stated	Not Stated	Not Stated	Not Stated
FREDERICK MEMORIAL	0005	120	Not Stated	18	Not Stated	Estate	Director, PFS
G.B.M.C	0044	90	Not Stated	Not Stated	Not Stated	Not Stated	CFO
GARRETT COUNTY	0017	120	Not Stated	Not Stated	Not Stated	Not Stated	CFO
HOLY CROSS	0004	90	No interest	6	Not Stated	Estate	Not Stated
KERNAN	2001	90	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
MARYLAND GENERAL	0038	75	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.
Mc CREADY	0045	60	Not Stated	Not Stated	Not Stated	Not Stated	CEO/Pres.
MERCY	0008	90	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
NORTHWEST HOSPITAL	0040	90	If Bad Debt	Not Stated	YES	YES	Not Stated
PENINSULA REGIONAL	0019	60	Not Stated	12	YES	YES	Not Stated
SAINT AGNES	0011	90	Not Stated	Not Stated	YES	Yes, Not primary res.	CEO/Pres.
SAINT JOSEPH'S	0007	120	No interest	9	Not Stated	Yes, Not primary res.	CEO/Pres.
SAINT MARY'S	0028	Not Stated	Not Stated	Not Stated	YES	YES	Not Stated
SINAI	0012	120	If Bad Debt	Not Stated	YES	Not Stated	Not Stated
SOUTHERN MARYLAND	0054	120	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
SUBURBAN	0022	120	If Bad Debt	12	Not Stated	Not Stated	Not Stated
UNION OF CECIL	0032	120	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
UNIVERSITY OF MD.	0002	90	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated
WASHINGTON COUNTY	0001	Not Stated	Not Stated	Not Stated	Not Stated	Not Stated	CFO

Source: HSCRC collected policies (with analysis performed by Hilltop Institute)

Summary of Maryland Hospital Credit and Collection Policies Informal Survey Results

This report summarizes current Maryland hospital credit and collection policies by reporting the results of an informal hospital survey completed in January 2009. The survey replicated a survey conducted and reported by the Commission in July 2006. In addition to the surveys, all hospitals were required to submit copies of their current credit and collection policies[1]. Individual hospital survey responses are attached to provide further detail regarding qualitative questions which cannot be quantified in a table.

According to the informal surveys regarding Maryland hospitals' internal collection policies, the first cycle of debt collection is usually conducted internally by the hospital and typically lasts approximately 90-120 days (one hospital noted that an outside agency handles all collection processes). In this stage, a patient typically receives statements and phone calls, with the focus on helping the patient understand his/her bill and to work on receipt of payment. If a patient agrees to a reasonable collection plan during this stage, most hospitals will stop the timing cycle for referring a patient account to a collection agency. Interest is not charged on a patient's bill during this stage. Generally, the statement includes a phone number that a patient can call to get their questions answered.

Once a patient account is referred to a collection agency, it is classified as bad debt. During this stage, the collection agency will check assets available by searching for a patient's property, debts, credit history, and overall availability of assets. In most cases, hospitals will allow the collection agency to note the debt on a patient's credit report while in this stage. In most cases, the collection agency will notify the hospital when a debt is considered uncollectable. Most hospitals will continue to classify the account as bad debt when it is determined uncollectable, however one hospital noted they sometimes re-classify the account as charity care.

When an agency is unsuccessful at collecting and finds that a patient does have available assets with which to pay the bill, it may recommend that the hospital take legal action. According to the survey, more than two thirds of the hospitals allow their collection agency to pursue legal action, but only after hospital review and approval. This has changed from the previous survey where approximately one half of the hospitals authorized their collection agency to pursue legal action. Legal action means that the hospital will ask a court to order the bill to be paid. Such steps may include garnishment of wages, putting a lien on a patient's home, and/or a claim on an estate.

Below are the list of questions that hospitals were asked as part of the HSCRC's informal hospital credit and collection survey. More detailed answers to survey questions can be found within the individual hospital survey responses, which are included as an attachment to this report.

Survey Question	**Response**[2]			
A. Internal Hospital Collection Policy				
If a patient gives no response to the hospital's	**45-59**	**60-89**	**90-119**	**120+**

[1] Individual hospital credit and collection policies are available for public review at the HSCRC's offices and on the HSCRC's website www.hscrc.state.md.us . Interested parties may also contact the HSCRC to review in person.

[2] N=43 responses, or 47 hospitals. Easton Memorial and Dorchester replied as one system response, Shady Grove and Washington Adventist replied as one system response, Prince Georges and Laurel Regional replied as one system response, and University of Maryland and Kernan replied as one system response. Additionally, 46 respondents are not-for-profit, and one is for-profit.

collection efforts, when does the hospital refer the account to a collection agency (in days)?	1	8	25	9
If a patient agrees to a reasonable collection plan with the hospital, does this stop the timing cycle for referring a patient's account to a collection agency?	**Yes**		**No**	
	41		2	
Does your hospital charge interest for payment plans for accounts in active AR? (Hospital rates and terms can be found within an individual hospital's response)	**Yes**		**No**	
	0		43	
Does your hospital bill include the following or a similar statement? "This bill is only for hospital services. You should expect a separate bill from your physician."	**Yes**		**No**	
	39		4	
Do you have a single phone number on the hospital bill that a patient can call to get their questions answered?	**Yes**		**No**	
	42		1	
If a patient has a history of previous non-payment, is the credit and collection process different? (e.g., immediate write-off to bad debt, commence full billing cycle?)	**Yes**		**No**	
	11		32	
If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's internal collection policy different (yes/no)? (Detailed explanations can be found in an individual hospital's response)	**Yes**		**No**	**N/A**
	16		26	1
B. External Hospital Collection Policy				
How is the account classified once it moves to a collection agency? (e.g., bad debt?)	**Bad Debt**		**Accounts Receivable**	
	43		0	
While a debt is at a collection agency, is the debt permitted to be noted on a patient's credit report? If yes, please provide details (when noted on credit report, how long, etc.).	**Yes**		**No**	
	32		11	
Who determines when an account should be considered uncollectible? (i.e., collection agency? Hospital?) After what period of time? (in days)	**Hospital**	**Collection Agency**	**Both**	
	14	13	16	
When an account is determined to be uncollectible, how does the hospital classify the account? (e.g., bad debt?)	**Bad Debt**	**Charity**	**Both/Either**	
	42	0	1	
Who determines whether or not a patient has	**Hospital**	**Collection Agency**	**Both**	

assets available to satisfy outstanding debt? (i.e., collection agency? Hospital?)	4	17	23
Is your collection agency authorized to pursue legal judgments? (e.g., garnishment of wages, Lien on assets - undertaken by hospital? Collection agency?)	**No answer**	**Yes**	**No**
	0	30	13
Does your hospital charge interest for accounts in bad debt collections? (Detail including rates and terms provided within individual hospital survey responses).	**Yes**	**No**	
	7	36	
In what circumstances will the hospital execute a legal judgment? (Examples provided within individual hospital survey responses).	**Qualitative response – Please see individual hospital survey responses**		
If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's external collection policy different (yes/no)? (If yes, explanations provided within individual hospital survey responses).	**No Answer**	**Yes**	**No**
	1	8	33

C. Other Credit and Collection Information

Does your hospital expend funds to enroll patients eligible for insurance coverage in such programs? (Names of programs/products and amount spent, if provided, included in individual hospital survey responses).	**Yes**	**No**	**Total Amount Spent**	**Average Amount Spent**
	37	6	$12,262,764.13	$285,180.56
What percentage of cases get turned over to a bad debt collection agency? Please use the following formula to calculate: **# of cases to bad debt collections/total number of cases**	**Average % of cases sent to bad debt**			
	13.04%			
What percentage of cases proceed to legal action? Please use the following formula to calculate: **# of cases to legal action/total number of cases**	**# of Hospitals less than 1%**		**Average % of cases referred to legal action**	
	33		1.97%	

Hospital	Auditor	NOTES	Notices Posted?	Content	Informed by other means?	F A	% where Policy followed 100%	Provide number and % of cases where not followed
			y/n		y/n			
Anne Arundel	KPMG		yes	financial counseling, office phone number	yes		0%	50 cases - 100%
Atlantic General	Cohen Rutherford & Knight		yes	same as financial assistance policy, phone number for pt accounting office	yes		49/50 - 98%	1 case - 2%
Baltimore Washington	KPMG		yes	application for Financial Assistance, Business Office phone number	yes		1 case - 2%	49 cases - 98%
Bon Secours	KPMG		yes	contact information, offer of help applying to government sponsored programs	yes		0	50 cases - 100%
Braddock	KPMG		yes	business office contact number and mention of Financial Assistance Program based on financial need	yes		0	50 cases - 100%
Calvert Memorial	Cohen Rutherford & Knight		yes	This hospital serves all patients regardless of ability to pay. Discounts for essential services are offered based on family size and income. ask registration for help	yes		49 cases - 98%	1 case - 2%
Carroll Hospital	KPMG		yes	committed to providing financial assistance and counseling for uninsured people	yes		1 case - 2%	49 cases - 98%
Chester River	KPMG		yes	committed to providing excellent care regardless of ability to pay - FA Program and phone number	yes		0	50 cases - 100%
Civista	Sacks, Trotta & Koppleman		yes	description of environment, patient aid program, telephone number	yes		40 cases - 80%	10 cases - 20%
Doctor's Community	Cohen Rutherford & Knight		yes	FA available, with/phone number	yes		37 cases - 74%	13 cases - 26%
Dorchester General	KPMG		yes	medical care regardless of ability to pay if no medical insurance, no funds, don't qualify for MA	yes		0	50 cases - 100%
Fort Washington	Cohen Rutherford & Knight		yes	hospital serves all patients regardless of ability to pay, discounts offered based on family size and income	yes		7 cases - 70%	3 cases - 30%
Franklin Square	KPMG		yes	committed to ensuring that uninsured patients who lack financial resources have access to necessary hospital services	yes		100%	0
Frederick Memorial	Ernst & Young		yes	informs patient of FA program	yes		**35 cases - 70%**	**15 cases - 30%**
Garrett County	Cohen Rutherford & Knight		yes	FA available, with/phone number	yes		46 cases - 92%	4 cases - 8%
GBMC	PriceWaterhouseCoopers		yes	how to apply for free and reduced care	yes		50 cases - 100%	0
Good Samaritan	KPMG		yes	committed to ensuring that uninsured patients who lack financial resources have access to necessary hospital services	yes		50 cases - 100%	0
Harbor Hospital	KPMG		yes	committed to ensuring that uninsured patients who lack financial resources have access to necessary hospital services	yes		50 cases - 100%	0
Harford Memorial	KPMG		yes	letter instructing patients how to apply for charity program and who to call with questions.	yes		33 cases - 66%	17 cases - 34%

Hospital	Auditor	Examples of Deviation	C&C	% where Policy followed 100%	Provide number and % of cases where not followed
Anne Arundel	KPMG	No determination of probable eligibility for financial assistance made within two days contained in patient folder.		92%	4 cases - 8%
Atlantic General	Cohen Rutherford & Knight	Authorization required by CEO/President for account forgiveness over the $5,000 threshold was not documented		100% with modification	0
Baltimore Washington	KPMG			22%	39 cases - 78%
Bon Secours	KPMG	documentation of approval/denial sent to patient missing from patient file, documentation of patient being approved or denied within 10 working days missing from patient file.		100%	0
Braddock	KPMG	documentation of insurance screening not available, insufficient documentation regarding proof of legal dependents, documentation of paperwork showing calculation of coverage based on the patient's maximum allowable income not in file, insufficient documentation regarding notification to patients within 2 days of determination of eligibility		96%	2 cases - 4%
Calvert Memorial	Cohen Rutherford & Knight	patient granted 100% assistance but should have only qualified for 40% assistance		47 cases - 94%	3 cases - 6%
Carroll Hospital	KPMG	insufficient documentation re: to determine if patient completed FA App and returned within 15days; to determine if FA were reviewed for various grant eligibilities; to determine if Fin Counselor had approved or denied within seven days of receipt		98%	1 case - 2%
Chester River	KPMG	hospital did not notify patient w/in 14days; completed application not maintained in file; lack of sufficient evidence to determine if personnel calculated income guidelines; lack of evidence to determine whether hospital personnel screened the patient for insurance; lack of evidence to determine if hospital management reviewed patient's FA application		76%	12 cases - 24%
Civista	Sacks, Trotta & Koppleman	Application not signed, no tax return, no unemployment wage letter, no social security wage letter or check, no documentation beyond application		49 cases - 98%	1 case - 2%
Doctor's Community	Cohen Rutherford & Knight	financial assistance provided in more liberal manner than if the policy had been followed		48 cases - 96%	2 cases - 4%
Dorchester General	KPMG	inability to determine if patients were screened for other assistance prior to applying for FA, support for proof of income not maintained in patient file, prior years' tax returns not maintained in patient file, support for dependants not maintained, check and savings statements not maintained, FA file did not include all bills claimed on application by patient, proof of residency not maintained, insufficient evidence to determine if calculation of income followed hospital policy.		1 case - 2%	49 cases - 98%
Fort Washington	Cohen Rutherford & Knight	patient granted 100% assistance but should have received partial assistance, income not verified, hospital unable to locate final determination letter		**Documentation not provided to auditors**	**documentation not provided to auditors**
Franklin Square	KPMG			50 cases - 100%	0
Frederick Memorial	Ernst & Young	hospital could not locate FA application, hospital did not obtain proof of income verification, FA provided without documenting eligibility requirements, incorrect percentage of financial assistance provided		**22 cases - 44%**	**28 cases - 56%**
Garrett County	Cohen Rutherford & Knight	annual income initially miscalculated, not all household income was required as per policy and patient was granted FA		**37 cases - 74%**	**13 cases - 26%**
GBMC	PriceWaterhouseCoopers	n/a		50 cases - 100%	0
Good Samaritan	KPMG	n/a		50 cases - 100%	0
Harbor Hospital	KPMG	n/a		50 cases - 100%	0
Harford Memorial	KPMG	FA approved by personnel over what that personnel allowed to approve, no adequate support provided for patient's income level and FA still provided		5 cases - 10%	45 cases - 90%

Hospital	Auditor	examples of Deviation	number and % of cases where Medicaid eligibility and cc activity applied	Recoveries	number and % of cases where recovery applied to bad debt expense or reserve	cases where gross amount of bill applied to bad debt expense	cases where gross amount not applied to bad debt expense
Anne Arundel	KPMG		0		100%	100%	0
Atlantic General	Cohen Rutherford & Knight		0		100%	100%	0
Baltimore Washington	KPMG		unable to determine/lack of documentation in patient record		100%	100%	0
Bon Secours	KPMG		0		100	100	0
Braddock	KPMG	instances where 2nd billing statements sent earlier than 30 days from first statement	unable to determine/lack of documentation in patient record		100	100	0
Calvert Memorial	Cohen Rutherford & Knight	accounts were transferred to CA after two statements, not three	0		100%	100%	0
Carroll Hospital	KPMG	none	none		100	100	0
Chester River	KPMG	accounts were selected for write off earlier than 60 days with no activity; deemed self-pay earlier than 60 days w/no payment;	unable to determine/lack of documentation in patient record		100	100	0
Civista	Sacks, Trotta & Koppleman	overpayment in one case	not addressed		100	100	0
Doctor's Community	Cohen Rutherford & Knight	system error, only one collection letter instead of two	none		100	100	0
Dorchester General	KPMG	attempts to contact patient earlier than 30 days, second statement sent earlier than 45 days, second attempt at contact earlier than 60 days, third statement earlier than 75 days, account closed to bad debt earlier than 90 days.	unable to determine/lack of documentation in patient record		41 cases/9 cases where the supporting evidence was insufficient	100	0
Fort Washington	Cohen Rutherford & Knight	**documentation not provided to auditors**			100	100	0
Franklin Square	KPMG	no deviations - information regarding pre-list review process not available due to record retention policies	none		100	100	0
Frederick Memorial	Ernst & Young	length of time between first notice and transfer to First Contact greater than 10 days, First Contact did not provide evidence that calls were made to patient, account not sent to First Contact	none		100	100	0
Garrett County	Cohen Rutherford & Knight	**13 patient accounts forwarded to collection agency 1-2 weeks early**	none		100	100	0
GBMC	PriceWaterhouseCoopers	n/a	none		100	100	0
Good Samaritan	KPMG	n/a	none		100	100	0
Harbor Hospital	KPMG		none		100	100	0
Harford Memorial	KPMG	10 day phone calls seldom made, follow-up calls reminding patients of delinquency seldom made.	unable to determine/lack of documentation in patient record		100	100	0

Hospital	Auditor	NOTES	Notices Posted?	Content	Informed by other means?	F A	% where Policy followed 100%	Provide number and % of cases where not followed
Holy Cross Hospital	Deloitte		yes	all patients have access to health care services regardless of ability to pay for necessary care	yes		2 cases - 4%	48 cases - 96%
Howard County General Hospital, Inc.	PriceWaterhouseCoopers		yes	how to apply for free and reduced care	yes		49 cases - 98%	1 case - 2%
James Lawrence Kernan	KPMG		yes	provides healthcare services to those in need regardless of an ability to pay, phone #	**upon inquiry**		1 case - 25%	3 cases - 75%
Johns Hopkins Bayview	PriceWaterhouseCoopers		yes	how to apply for free and reduced care	yes		50 cases - 100%	0
Laurel Regional	Cohen Rutherford & Knight		yes	Financial Assistance Programs	yes		50 cases - 100%	0 cases - 0%
Maryland General	KPMG		yes	see registration staff or financial services if you are concerned about hospital bill	yes		0	50 cases - 100%
McCready Memorial	Scott Tawes & Associates, CPA		yes		yes		49 cases - 98%	1 case - 2%
Memorial Hospital at Easton	KPMG		yes	dedicated to assisting our community members with obtaining medical care regardless of their ability to pay, FA program phone number	yes		0	50 cases - 100%
Memorial of Cumberland	KPMG		yes	Financial Assistance Program based on financial need and phone number of business office	yes		0 cases - 0%	43 cases - 100%
Mercy	Cohen Rutherford & Knight		yes	Introduction, when to apply, covered services, eligibility requirements	yes		50 cases - 100%	0 cases - 0%
Montgomery General	KPMG		yes	committed to ensuring that uninsured patients who lack financial resources have access to necessary hospital services	yes		14 cases - 28%	36 cases - 72%
Northwest Hospital	**KPMG**		**no**	**Northwest Hospital has a Financial assistance program based on financial need**	**yes**		**0**	**50 cases - 100%**
Peninsula Regional	Ernst & Young		yes	informs patient of FA program	yes		**16 cases - 32%**	**34 cases - 68%**
Prince Georges	Cohen Rutherford & Knight		yes	FA Programs	yes		50 cases - 100%	0 cases - 0%
Shady Grove Adventist	ParenteRandolph		yes		yes		42 cases - 84%	8 cases - 16%
Sinai	KPMG		yes	Financial Assistance Notice	yes		**0**	**50 cases - 100%**

Hospital	Auditor	Examples of Deviation	C&C	% where Policy followed 100%	Provide number and % of cases where not followed
Holy Cross Hospital	Deloitte	applications approved for higher percentage of FA than specified on schedule, applications approved for lower percentage of FA then specified on schedule, require patient signature missing, all supporting documents not in file, unable to determine if decision made within 2 days because date not available, not approved within 2 days as specified in policy		**5 cases - 10%**	**45 cases - 90%**
Howard County General Hospital, Inc.	PriceWaterhouseCoopers	patient did not provide support for income since the patient was unemployed. HCGH accepted a letter of support from a family member and 2 consecutive monthly bank statements. The patient was granted 100 % financial assistance.		50 cases - 100%	0 cases -0%
James Lawrence Kernan	KPMG	support for bills not maintained in patient file, proof of income not in file, application missing signature, lack of information to determine if patient screened for other assistance programs, inability to determine if co-payment obligations met, inability to determine if patient exhausted all other benefits, inability to determine if patient's insurance denied coverage before financial clearance was granted		45 cases - 90%	5 cases - 10%
Johns Hopkins Bayview	PriceWaterhouseCoopers	n/a		50 cases - 100%	0 cases -0%
Laurel Regional	Cohen Rutherford & Knight			34 cases - 70.8%	14 cases - 29.2%
Maryland General	KPMG	inability to determine if hospital exhausted all possible sources of payment before FA granted, missing documentation of proof of income, patient did not reside in primary service area, valid SS card not in file, date of determination of FA not in file, determination letter not maintained in file		49 cases - 98%	1 case - 2%
McCready Memorial	Scott Tawes & Associates, CPA	notes inconclusive of verification or presence of financial assistance application/approval		53 cases - 88%	7 cases - 11%
Memorial Hospital at Easton	KPMG	inability to determine if patients were screened for other assistance prior to applying for FA, support for income not in file, tax return or w2 not in file, support for dependants not maintained in file, checking and savings statements not in patient file, FA app did not include copies of all bills claimed by patient, proof of residency not maintained, insufficient evidence of income calculation in accordance with hospital policies		6 cases - 12%	44 cases - 88%
Memorial of Cumberland	KPMG	inability to determine if patients were screened for all other forms of insurance, insufficient documentation of proof of legal dependants, insufficient documentation to determine if hospital maintained calculation of coverage based on patient's max allowed income, insufficient documentation to determine if patient notified within 2 business days of determination of eligibility		48 cases - 96%	2 cases - 4%
Mercy	Cohen Rutherford & Knight			48 cases - 96%	2 cases - 4%
Montgomery General	KPMG	unable to determine if patient was notified in writing within three business days of the determination of eligibility		41 cases - 82%	9 cases - 18%
Northwest Hospital	**KPMG**	**hospital does not maintain a listing of when applications are received, therefore it could not be determined whether written approval or denial was provided within 2 days**		**49 cases - 98%**	**1 case - 2%**
Peninsula Regional	Ernst & Young	patient's net assets were greater than requested assistance and no lien was placed, approval was given outside of 6 month window, request for uncompensated care form completed incorrectly, income above threshold and assistance still granted, approval provided without evidence of patient income, patient not notified with 48 hours		48 cases - 96%	2 cases - 4%
Prince Georges	Cohen Rutherford & Knight			35 cases - 77.8%	10 cases - 22.2%
Shady Grove Adventist	ParenteRandolph	application approved, but no application provided for review, patient approved by third party administrator and no application provided, approved at 60% but documentation shows it should have been at 50%		50 cases - 100%	0 cases -0%
Sinai	KPMG	management does not maintain a listing of when applications are received - therefore unable to determine if approval or denial provided within 2 days of application		48 cases - 96%	2 cases - 4%

Hospital	Auditor	examples of Deviation	number and % of cases where Medicaid eligibility and cc activity applied	Recoveries	number and % of cases where recovery applied to bad debt expense or reserve	cases where gross amount of bill applied to bad debt expense	cases where gross amount not applied to bad debt expense
Holy Cross Hospital	Deloitte	bills not sent out one day after receipt of insurance payment, timing and quantity on consistent with policy,	none		49 cases - 98%	1 case not enough documentation	1 case not enough documentation
Howard County General Hospital, Inc.	PriceWaterhouseCoopers	n/a	0		50 cases - 100%	50 cases - 100%	0
James Lawrence Kernan	KPMG	accounts written off prior to 90 days, two letters not always sent to patient.	unable to determine/lack of documentation in patient record		100	100	0
Johns Hopkins Bayview	PriceWaterhouseCoopers	n/a	0		50 cases - 100%	50 cases - 100%	0
Laurel Regional	Cohen Rutherford & Knight	phone calls not made per policy, letters not sent according to policy, account transferred to bad debt earlier than standard	0		100	100	0
Maryland General	KPMG	inability to determine if notices sent to patients on a 30 day cycle, accounts being written off before 75 days	unable to determine/lack of documentation in patient record		100	100	0
McCready Memorial	Scott Tawes & Associates, CPA	time lapse between changing to private pay from Medicare or insurance financial class to bad debt and write off.	not addressed		100	100	0
Memorial Hospital at Easton	KPMG	attempts to contact patient earlier than 30 days, second statement sent earlier than 45 days, second attempt at contact earlier than 60 days, third statement earlier than 75 days, account closed to bad debt earlier than 90 days.	unable to determine/lack of documentation in patient record		4 cases had insufficient evidence of debt collection agency invoice,	100	0
Memorial of Cumberland	KPMG	2nd statement sent earlier than 30 days	unable to determine/lack of documentation in patient record		100	100	0
Mercy	Cohen Rutherford & Knight	account not approved by appropriate personnel before being transferred to bad debt, account received a payment but was transferred to bad debt	0		100	100	0
Montgomery General	KPMG	insufficient documentation to determine whether the Hospital had requested payment from self-pay patients during his/her in-house stay.	0		100	100	0
Northwest Hospital	**KPMG**	**ar balance was greater than 180 days and was not sent to second collection agency in accordance with hospital policy**	**0**		**100**	**100**	**0**
Peninsula Regional	Ernst & Young	outstanding patient accounts greater than $125 not called by collection rep before writing off balance, sent to collections prior to 60 day period,	2 cases		100	100	0
Prince Georges	Cohen Rutherford & Knight	phone calls not made per policy, patient communicated eob stated payment made in full	0		100	100	0
Shady Grove Adventist	ParenteRandolph	none	0		100	100	0
Sinai	KPMG	none listed	0		100	100	0

Hospital	Auditor	NOTES	Notices Posted?	Content	Informed by other means?	F A	% where Policy followed 100%	Provide number and % of cases where not followed
Southern Maryland	Ernst & Young		yes	hospital provides partial or complete FA for patients who do not qualify for any other assistance, phone number	yes		38 cases - 76%	12 cases - 24%
St. Agnes	Clifton Gunderson		yes	Financial Assistance is available for qualified patients, phone number	yes		29 cases - 58%	21 cases - 42%
St. Joseph	Ernst & Young		yes	FA Programs	yes		49 cases - 98%	1 case - 2%
St. Mary's	Cohen Rutherford & Knight		yes	Payment Assistance	yes		37 cases - 74%	13 cases - 26%
Suburban Hospital	Cohen Rutherford & Knight		yes	Information about applying for FA and phone number	yes		49 cases - 98%	1 case - 2%
The Johns Hopkins Hospital	PriceWaterhouseCoopers		yes	how to apply for free and reduced care	yes		50 cases - 100%	0
Union Hospital of Cecil County, Inc.	ParenteRandolph		yes	not given	yes		50 cases - 100%	0
Union Memorial	KPMG		yes	will work with uninsured patients who do not qualify for state or federal support	yes		50 cases - 100%	0 cases - 0%
University of Maryland Medical System Corporation	KPMG		yes	provides healthcare services to those in need regardless of an ability to pay, phone #	only if patient inquires		0 cases - 0%	50 cases - 100%
Upper Chesapeake	KPMG		yes	Financial Assistance Program based on financial need and phone number of business office	yes		33 cases - 66%	17 cases - 34%
Washington Adventist	ParenteRandolph		yes	all patients informed of availability of FA	yes		40 cases - 80%	10 cases - 20%
Washington County	Grant Thornton		yes	summary of program including eligiblity requirements	yes		50 cases - 100%	0

Hospital	Auditor	Examples of Deviation	C&C	% where Policy followed 100%	Provide number and % of cases where not followed
Southern Maryland	Ernst & Young	no evidence that FA application was completed or that application exception was approved, no evidence of department head signature, form of patient notification is not documented		50 cases - 100%	0 cases -0%
St. Agnes	Clifton Gunderson	all required approvals were not obtained before providing FA, incomplete applications,		32 cases - 64%	18 cases - 36%
St. Joseph	Ernst & Young	absence of Director of Revenue Cycle Approval Signature		35 cases - 70%	15 cases - 30%
St. Mary's	Cohen Rutherford & Knight	services performed more than six months prior to date of application, hospital unable to locate the FA application documentation, account forgiven over the policy threshold, patient had income over the federal poverty level		31 cases - 62%	19 cases - 38 % not enough documentation
Suburban Hospital	Cohen Rutherford & Knight	patient was inappropriately denied financial assistance because the household size was overlooked when comparing to the federal poverty limits. Subsequently corrected		50 cases - 100%	0 cases -0%
The Johns Hopkins Hospital	PriceWaterhouseCoopers			50 cases - 100%	0 cases -0%
Union Hospital of Cecil County, Inc.	ParenteRandolph	n/a		50 cases - 100%	0 cases -0%
Union Memorial	KPMG	no deviations		50 cases - 100%	0 cases -0%
University of Maryland Medical System Corporation	KPMG	Financial Clearance files could not be found, support for bills claimed on application not maintained in file, proof of income not maintained, unable to determine if patient is legal resident of Maryland, inability to determine if patients were screened for other assistance, inability to determine if co-payment obligations were fulfilled, inability to determine if all other benefits were exhausted, inability to determine if insurance program denied coverage, inability to determine if financial clearance was being sought for supervised living accommodations or meals while patient in day program		47 cases - 94%	3 cases - 6%
Upper Chesapeake	KPMG	financial assistance amount approved by hospital personnel over respective personnel's approval limit, no financial determination form approved in the patient file, and FA still approved		2 cases - 4%	48 cases - 96%
Washington Adventist	ParenteRandolph	application was approved but none could be provided for review, patient provided more than was approved, patient approved but accounting system showed denied, patient approved for more than was provided,		50 cases - 100%	0 cases -0%
Washington County	Grant Thornton	n/a		50 cases - 100%	0 cases -0%

Hospital	Auditor	examples of Deviation	number and % of cases where Medicaid eligibility and cc activity applied	Recoveries	number and % of cases where recovery applied to bad debt expense or reserve	cases where gross amount of bill applied to bad debt expense	cases where gross amount not applied to bad debt expense
Southern Maryland	Ernst & Young	none	0		100	100	0
St. Agnes	Clifton Gunderson	no notation that contact to the patient for balance was made, 2 statements mailed instead of three	1 case - 2%		unclear	unclear	unclear
St. Joseph	Ernst & Young	Account not classified under "bad debt status" once 120 days past due	0		10 cases - 20%	10 cases - 20%	40 cases - 80%, these represent recoveries of patient accounts in "bad debt status" that had not yet been deemed uncollectable
St. Mary's	Cohen Rutherford & Knight	documentation for bad debt account did not include evidence of approval for transfer to a collection agency by the appropriate patient financial services personnel.	0		100	100	0
Suburban Hospital	Cohen Rutherford & Knight	none	0		100	100	0
The Johns Hopkins Hospital	PriceWaterhouseCoopers	n/a	0		50 cases - 100%	50 cases - 100%	0
Union Hospital of Cecil County, Inc.	ParenteRandolph	n/a	0		50 cases - 100%	50 cases - 100%	0
Union Memorial	KPMG		0		100	100	0
University of Maryland Medical System Corporation	KPMG	accounts written off prior to 90 days, two letters not always sent to patient.	unable to determine/lack of documentation in patient record		100	100	0
Upper Chesapeake	KPMG	10 day phone calls seldom made, follow-up phone calls seldom made to remind patients of delinquency	unable to determine/lack of documentation in patient record		100	100	0
Washington Adventist	ParenteRandolph		3 cases		50 cases - 100%	50 cases - 100%	5 cases where supportive documentation not available
Washington County	Grant Thornton	n/a	0		50 cases - 100%	50 cases - 100%	0

Appendix V

Summary of Interest Rates and Applicable Statutes for Late/Non- payment of Hospitals Bills

Interest	**Insurers/HMOs/Nonprofit Health Service Plans issued in MD** **TPAs that are MD Insurers, HMOs or Nonprofit Service Plans**	**ERISA**	**Self-pay (uninsured)**
Before a court judgment is obtained: **Statute/Regulation:**	1.5% from 31st to 60th day 2% from 61st to 120th day 2.5% after the 120th day Insurance Article – 15-1005	1% per month beginning on the 61st day COMAR 10.37.10.26B(3)	0% Health General Article - 19-214.2(B)(3) [effective June 1, 2009]
Post-judgment: **Statute:**	10% per annum (Court proceedings could alter pre-judgment interest) CJ 11-107	10% per annum (Court proceedings could alter pre-judgment interest) CJ 11-107	10% per annum Court proceedings could alter pre-judgment interest CJ 11-107

Appendix VI

Appendix VI

JUDGMENTS, JUDGMENT LIENS AND SECURED CREDITORS AND REAL PROPERTY MORTGAGES

This memo is to clarify the status of creditors that hold a mortgage, lien, or judgment lien and when a creditor can take action to execute on a judgment.

In general, the entry of a judgment is governed by the Maryland Rules of Court. When one party sues another party the Maryland Rules apply to the process of filing the suit, entry of the judgment and collection on the judgment. Lawsuits filed in the Circuit Court are governed generally by Chapter 2 of the Maryland Rules and lawsuits filed in the District Court are governed generally by Chapter 3 of the Maryland Rules. (I say generally because there are some exceptions and other Maryland statutes that apply).

A judgment is a determination by a Court in favor of a party to a lawsuit and a money judgment is a determination that a certain amount of money is immediately payable to the judgment creditor. Ann. Code of Md., Cts & Jud. Proc. §11-401(c). The judgment itself is simply a piece of paper but once the money judgment is indexed and recorded pursuant to the Maryland Rules, it becomes a judgment lien on the debtor's interest in land in the county where the judgment was entered from the date the judgment indexed and recorded. Maryland Rule 2-621, 3-621. However, for money judgments entered in Baltimore City the judgment becomes a lien on the date of entry of the judgment, instead of the date of recording. Maryland Rule 3-621. If the debtor has land in another county then the money judgment must be indexed and recorded with the clerk of the other county.Ann. Code of Md., Cts & Jud. Proc. §11-402(b) and (c). Maryland Rule 2-622, 2-622. Thus a prevailing party must ensure that the clerk indexes and records the money judgment in order that it become a lien on land or a lease hold interest with a term of more than 5 years that can be renewed, such as a person owning a residence with a ground rent. If a judgment creditor wishes to place a judgment lien on property held by a judgment debtor in a county other than where the judgment was entered, the creditor must make this request to the clerk of the county and ensure that the clerk does enter the judgment in that county's records.

There is no similar judgment lien on personal property. Instead the creditor must first levy on personal property for the money judgment to become a lien. Ann. Code of Md., Cts & Jud. Proc. §11-403. Once there is a levy on personal property, the property can be sold at a sheriff's sale or the creditor can decide to collect the debt through a writ of execution to garnish wages or garnish property other than wages, such as money in a bank account. A judgment is valid for 12 years and the creditor must renew the judgment before the 12 year period expires or the judgment will cease to exist. Maryland Rule 2-625, 3-625.

When a judgment is entered by a court the prevailing party will want to ensure that the judgment is recorded for once it is recorded, it can become a judgment lien on real property. The judgment once recorded will become a lien on land that is currently held by the judgment debtor or future land that the debtor may purchase or inherit.

A judgment creditor cannot sell land that is held as tenants by the entireties if it holds a judgment against just one tenant. Tenants by the entireties property is property jointly held as husband and wife. If property is held as joint tenants, the judgment lien cannot attach until after the joint tenancy is severed. *Eastern Shore Bldg. & Loan Corp. v. Bank of Somerset*, 253 Md. 525, 253 A. 2d 367 (1969).

Status and Priority

There are three categories of creditors – Priority, secured and unsecured. A priority creditor is typically one that a legislative body has determined has a special status and must be paid before all other creditors or be granted a lien. A example of such creditors are taxing authorities or municipalities. A secured creditor is one that has a right to personal or real property because of a consensual agreement between the parties whereby one party has granted a consensual lien to another in exchange for some consideration, usually money. A typical example of a secured creditor is a mortgage company or a company that has financed a vehicle. If the debtor does not make payments on the debt, the creditor can sell the house at foreclosure or repossess the vehicle and sell the vehicle. A secured creditor may also hold a nonconsensual lien through the entry of a judgment. A creditor that has a judgment may be secured by real property if there is equity in the real property. Once the judgment is recorded, the judgment lien becomes secured by the equity in the property. An unsecured creditor is one that holds no security in property. It can be a party that has not yet filed a lawsuit or a party that has filed a lawsuit but the debtor has no real property available that will secure the judgment lien.

Who has priority to real property? The creditor who has priority to real property is the creditor who has received a judgment and recorded first. In a typical scenario, a consumer debtor who owns a house will have a mortgage on the house and that mortgage company will have filed the Deed of Trust with the county (or Baltimore City) land records. Any creditor who sues the consumer debtor thereafter and records in time and as permitted by the Maryland Rules will have priority over other creditors, except the mortgage or the holder of a tax lien. Thus, if a consumer debtor owes a mortgage balance, and is sued and a judgment entered by ABC hospital who properly records its judgment, and is then sued by Visa, who is granted a judgment and properly records its judgment, the mortgage is senior to ABC hospital and the hospital's lien, because it was recorded prior to Visa's lien, is senior to Visa. If the hospital decides not to execute its judgment lien on the real property, but Visa decides it wants to execute its lien, Visa will be paid its claim, only after the auctioneer, the mortgage, and ABC hospital have been paid. Further, the execution of the judgment lien is a forced sale and for that reason, the property is normally not sold in that public forum for its market value. The sale may only bring enough to pay off the

mortgage or the mortgage and one creditors. For that reason, a creditor such as Visa may wait to try to collect on its judgment until the house is sold.

If a person dies and property is transferred, it is transferred subject to any judgment or tax liens or other priority liens that may exist on the property. Whoever receives the property by transfer as a result of a will or deed does not have clear title on the real property until the debt is paid. Thus, if a consumer debtor has provided in a Deed that upon his death, his interest in the real property goes to his minor son, the son takes it subject to the liens on the house and any lien holder can attempt to collect on the debt. If there is no estate, a creditor can open an estate to take action against the property.

Other ways creditors can collect

In addition to executing on real property, creditors are more likely to undertake judicial collection efforts through garnishment of wages, bank accounts, and a levy and possible sale of personal items. These measures are less costly and much quicker.

Appendix VII

Appendix VII

Draft Recommendation on Handling Charity Care in the Uncompensated Care Provision

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(410) 764-2605

September 2, 2009

This recommendation is a draft proposal. No Commission action is required at this time. Public comments should be sent to Nduka Udom at the above address or by e-mail at ndukau@hscrc.state.md.us. For full consideration, comments should be received by October 2, 2009.

Purpose

The purpose of this recommendation is to incentivize Maryland hospitals to provide more charity care and to appropriately report to the Commission just how much charity care they provide. The problems highlighted by the *Baltimore Sun* articles on Maryland hospitals and uncompensated care prompted the legislature to enact legislation that allows the Commission to establish thresholds higher than 150% of the Federal Poverty Level (FPL) and to take into account patient mix, financial condition, level of bad debt, and level of charity care in establishing those thresholds.

Over the past few months, the Commission staff has been working on a broad range of possible measures that can be used to account for the level of Charity Care in the Uncompensated Care Provision built into rates for Maryland hospitals. Staff completed its work in June 2009.

Model

The model for the Uncompensated Care remains as specified in the current methodology with all its attendant computations. However, the amount of uncompensated care in rates before the 100% Pooling Level is established would be computed as follows:

1. Take the current policy results by hospital and make the charity care adjustments to them (Charity care adjustment is calculated as a fraction of the percent of hospital gross patient revenue that is charity Care); and

2. Calculate the revenue neutrality adjustment as a proportional adjustment to neutralize the impact of the charity care adjustment and adjust the statewide Uncompensated Care Provision to the appropriate level.

Data Analysis and Result

Staff has performed analysis based on the approach described above. The results of this modeling are presented in Tables 1 and 2. The results show that hospitals whose ratio of charity care to current policy results exceeds the statewide ratio will receive positive charity care adjustments while, conversely, hospitals whose ratio of charity care to current policy results is less than the statewide ratio will receive negative charity care adjustments.

Recommendation

The staff recommends that the Commission change its method for calculating prospective levels of uncompensated care for Maryland hospitals by adding the charity care adjustments to the existing methodology. The new method would be effective July 1, 2010 (rate year 2011) and will use data submitted for fiscal year 2009.

Table 1

Difference Between Current Policy and Proposed Policy Results for FY 2011

Hospid	Hospital Name	Actual UCC	Percent of Gross Patient Revenue that is Charity Care	Current Policy Results	Proposed Policy Results	Difference	Ratio of charity care to Current Policy Result	Proposed greater than current policy result
210017	Garrett County Memorial Hospital	9.30%	5.47%	7.71%	8.31%	0.61%	71.01%	1
210029	Johns Hopkins Bayview Med. Center	9.36%	5.16%	8.87%	9.35%	0.48%	58.20%	1
210018	Montgomery General Hospital	5.55%	3.92%	6.72%	7.09%	0.37%	58.23%	1
210011	St. Agnes Hospital	6.24%	3.53%	7.16%	7.43%	0.27%	49.25%	1
210001	Washington County Hospital	7.99%	3.55%	7.42%	7.68%	0.26%	47.79%	1
210027	Braddock Hospital	4.75%	2.41%	4.75%	4.94%	0.19%	50.77%	1
210002	Univ. of Maryland Medical System	9.48%	3.75%	9.71%	9.88%	0.17%	38.59%	1
210045	McCready Foundation, Inc.	10.27%	3.39%	8.93%	9.07%	0.14%	38.00%	1
210057	Shady Grove Adventist Hospital	6.66%	2.84%	7.63%	7.74%	0.11%	37.29%	1
210025	The Memorial Hospital	5.48%	2.25%	5.64%	5.75%	0.11%	39.91%	1
210033	Carroll County General Hospital	5.64%	2.32%	5.91%	6.02%	0.11%	39.19%	1
210004	Holy Cross Hospital of Silver Spring	7.37%	2.46%	6.85%	6.94%	0.08%	35.88%	1
210009	Johns Hopkins Hospital	6.08%	2.25%	6.22%	6.30%	0.08%	36.20%	1
210016	Washington Adventist Hospital	9.98%	2.90%	8.60%	8.67%	0.07%	33.69%	1
210019	Peninsula Regional Medical Center	6.50%	2.16%	6.11%	6.18%	0.07%	35.26%	1
210028	St. Marys Hospital	6.29%	2.62%	7.75%	7.81%	0.06%	33.79%	1
210024	Union Memorial Hospital	6.93%	2.27%	6.66%	6.72%	0.06%	34.17%	1
210008	Mercy Medical Center, Inc.	7.41%	2.56%	7.77%	7.83%	0.05%	32.94%	1
210007	St. Josephs Hospital	3.36%	1.06%	3.27%	3.28%	0.02%	32.48%	1
210022	Suburban Hospital Association,Inc	5.04%	1.55%	5.12%	5.12%	0.01%	30.34%	1
210013	Bon Secours Hospital	17.08%	4.64%	15.74%	15.75%	0.00%	29.47%	1
210005	Frederick Memorial Hospital	5.62%	1.86%	6.35%	6.35%	-0.00%	29.23%	0
210015	Franklin Square Hospital	8.09%	2.51%	8.56%	8.56%	-0.00%	29.28%	0
210030	Chester River Hospital Center	11.90%	2.31%	8.28%	8.25%	-0.02%	27.86%	0
210040	Northwest Hospital Center, Inc.	7.97%	2.20%	8.07%	8.04%	-0.03%	27.22%	0
210023	Anne Arundel General Hospital	4.68%	1.12%	4.77%	4.71%	-0.05%	23.50%	0
210012	Sinai Hospital	8.03%	1.91%	7.60%	7.54%	-0.06%	25.15%	0
210056	Good Samaritan Hospital	5.80%	1.41%	5.98%	5.91%	-0.07%	23.53%	0
210061	Atlantic General Hospital	5.48%	1.36%	5.97%	5.90%	-0.08%	22.70%	0
210044	Greater Baltimore Medical Center	2.81%	0.39%	3.41%	3.29%	-0.12%	11.38%	0
210039	Calvert Memorial Hospital	5.72%	1.24%	6.64%	6.50%	-0.13%	18.65%	0
210049	Upper Chesepeake Medical Center	5.90%	1.00%	6.14%	5.98%	-0.15%	16.32%	0
210043	North Arundel General Hospital	7.94%	1.33%	7.83%	7.65%	-0.18%	17.01%	0
210037	Memorial Hospital at Easton	5.71%	0.60%	5.92%	5.71%	-0.21%	10.21%	0
210034	Harbor Hospital Center	8.94%	1.75%	9.87%	9.66%	-0.22%	17.76%	0
210048	Howard County General Hospital	5.21%	0.66%	6.22%	5.99%	-0.22%	10.56%	0
210032	Union Hospital of Cecil County	7.76%	1.09%	8.28%	8.02%	-0.25%	13.15%	0
210035	Civista Medical Center	7.43%	0.78%	7.28%	7.02%	-0.26%	10.75%	0
210010	Dorchester General Hospital	5.97%	1.06%	8.41%	8.14%	-0.27%	12.55%	0
210006	Harford Memorial Hospital	11.95%	1.40%	9.59%	9.32%	-0.27%	14.54%	0
210058	James Lawrence Kernan Hospital	6.22%	0.50%	6.58%	6.31%	-0.27%	7.60%	0
210054	Southern Maryland Hospital	9.49%	0.68%	8.47%	8.12%	-0.34%	8.04%	0
210060	Fort Washington Medical Center	14.20%	1.40%	11.78%	11.39%	-0.39%	11.85%	0
210051	Doctors Community Hospital	10.88%	0.43%	9.84%	9.38%	-0.47%	4.36%	0
210038	Maryland General Hospital	12.71%	0.78%	12.56%	12.01%	-0.55%	6.23%	0
210055	Laurel Regional Hospital	12.63%	0.28%	11.27%	10.70%	-0.57%	2.50%	0
210003	Prince Georges Hospital	14.93%	0.61%	14.19%	13.51%	-0.67%	4.31%	0
	STATE-WIDE	7.39%	2.17%	7.39%	7.39%	-0.00%	29.41%	

Table 2

Policy Results from the Regression, Charity Care Adjustment and Revenue Neutrality Adjustment for FY 2011

Hospid	Hospital Name	UCC in Rates	Actual UCC	Predicted UCC	FY '06 - FY '08 UCC AVERAGE	50/ 50 BLENDED UCC AVERAGE	Revenue Neutrality Adjustment	Current Policy Results	Percent of Gross Patient Revenue that is Charity Care	Charity Care Adjustment	Preliminary Policy Results	Proposed Policy Results
1	2	3	4	5	6	7 = (Col 5 + Col 6)*0.5	8	9 = (Col 7 + Col 8)	10	11 = (Col 10*0.2)	12 = (Col 9 + Col 11)	13
210001	Washington County Hospital	6.67%	7.99%	7.24%	7.51%	7.38%	0.05%	7.42%	3.55%	0.71%	8.13%	7.68%
210002	Univ. of Maryland Medical System	8.69%	9.48%	9.65%	9.67%	9.66%	0.05%	9.71%	3.75%	0.75%	10.46%	9.88%
210003	Prince Georges Hospital	13.35%	14.93%	14.05%	14.22%	14.14%	0.05%	14.19%	0.61%	0.12%	14.31%	13.51%
210004	Holy Cross Hospital of Silver Spring	6.43%	7.37%	6.85%	6.76%	6.80%	0.05%	6.85%	2.46%	0.49%	7.34%	6.94%
210005	Frederick Memorial Hospital	5.62%	5.62%	7.02%	5.59%	6.31%	0.05%	6.35%	1.86%	0.37%	6.73%	6.35%
210006	Harford Memorial Hospital	8.24%	11.95%	8.71%	10.38%	9.55%	0.05%	9.59%	1.40%	0.28%	9.87%	9.32%
210007	St. Josephs Hospital	2.81%	3.36%	3.46%	2.97%	3.22%	0.05%	3.27%	1.06%	0.21%	3.48%	3.28%
210008	Mercy Medical Center, Inc.	7.79%	7.41%	7.56%	7.89%	7.73%	0.05%	7.77%	2.56%	0.51%	8.29%	7.83%
210009	Johns Hopkins Hospital	5.65%	6.08%	6.41%	5.94%	6.18%	0.05%	6.22%	2.25%	0.45%	6.67%	6.30%
210010	Dorchester General Hospital	8.25%	5.97%	9.38%	7.34%	8.36%	0.05%	8.41%	1.06%	0.21%	8.62%	8.14%
210011	St. Agnes Hospital	7.07%	6.24%	7.62%	6.62%	7.12%	0.05%	7.16%	3.53%	0.71%	7.87%	7.43%
210012	Sinai Hospital	7.06%	8.03%	7.13%	7.98%	7.55%	0.05%	7.60%	1.91%	0.38%	7.98%	7.54%
210013	Bon Secours Hospital	13.68%	17.08%	16.33%	15.06%	15.70%	0.05%	15.74%	4.64%	0.93%	16.67%	15.75%
210015	Franklin Square Hospital	7.93%	8.09%	8.75%	8.28%	8.51%	0.05%	8.56%	2.51%	0.50%	9.06%	8.56%
210016	Washington Adventist Hospital	7.29%	9.98%	7.63%	9.48%	8.56%	0.05%	8.60%	2.90%	0.58%	9.18%	8.67%
210017	Garrett County Memorial Hospital	8.08%	9.30%	7.82%	7.50%	7.66%	0.05%	7.71%	5.47%	1.09%	8.80%	8.31%
210018	Montgomery General Hospital	6.03%	5.55%	7.05%	6.30%	6.68%	0.05%	6.72%	3.92%	0.78%	7.51%	7.09%
210019	Peninsula Regional Medical Center	5.56%	6.50%	5.88%	6.25%	6.07%	0.05%	6.11%	2.16%	0.43%	6.54%	6.18%
210022	Suburban Hospital Association,Inc	4.71%	5.04%	5.30%	4.83%	5.07%	0.05%	5.12%	1.55%	0.31%	5.43%	5.12%
210023	Anne Arundel General Hospital	4.36%	4.68%	4.85%	4.59%	4.72%	0.05%	4.77%	1.12%	0.22%	4.99%	4.71%
210024	Union Memorial Hospital	6.33%	6.93%	6.09%	7.13%	6.61%	0.05%	6.66%	2.27%	0.45%	7.11%	6.72%
210025	The Memorial Hospital	4.86%	5.48%	6.09%	5.09%	5.59%	0.05%	5.64%	2.25%	0.45%	6.09%	5.75%
210027	Braddock Hospital	4.06%	4.75%	4.79%	4.61%	4.70%	0.05%	4.75%	2.41%	0.48%	5.23%	4.94%
210028	St. Marys Hospital	6.51%	6.29%	9.69%	5.71%	7.70%	0.05%	7.75%	2.62%	0.52%	8.27%	7.81%
210029	Johns Hopkins Bayview Med. Center	8.68%	9.36%	8.27%	9.37%	8.82%	0.05%	8.87%	5.16%	1.03%	9.90%	9.35%
210030	Chester River Hospital Center	7.39%	11.90%	5.77%	10.68%	8.23%	0.05%	8.28%	2.31%	0.46%	8.74%	8.25%
210032	Union Hospital of Cecil County	7.89%	7.76%	8.88%	7.57%	8.23%	0.05%	8.28%	1.09%	0.22%	8.49%	8.02%
210033	Carroll County General Hospital	5.17%	5.64%	6.87%	4.86%	5.87%	0.05%	5.91%	2.32%	0.46%	6.38%	6.02%
210034	Harbor Hospital Center	9.05%	8.94%	10.57%	9.08%	9.83%	0.05%	9.87%	1.75%	0.35%	10.23%	9.66%
210035	Civista Medical Center	6.10%	7.43%	8.58%	5.88%	7.23%	0.05%	7.28%	0.78%	0.16%	7.43%	7.02%
210037	Memorial Hospital at Easton	5.92%	5.71%	6.62%	5.14%	5.88%	0.05%	5.92%	0.60%	0.12%	6.05%	5.71%
210038	Maryland General Hospital	11.59%	12.71%	13.21%	11.82%	12.51%	0.05%	12.56%	0.78%	0.16%	12.72%	12.01%
210039	Calvert Memorial Hospital	6.14%	5.72%	7.44%	5.74%	6.59%	0.05%	6.64%	1.24%	0.25%	6.89%	6.50%
210040	Northwest Hospital Center, Inc.	7.30%	7.97%	8.17%	7.88%	8.03%	0.05%	8.07%	2.20%	0.44%	8.51%	8.04%
210043	North Arundel General Hospital	6.73%	7.94%	8.08%	7.48%	7.78%	0.05%	7.83%	1.33%	0.27%	8.10%	7.65%
210044	Greater Baltimore Medical Center	2.54%	2.81%	4.03%	2.69%	3.36%	0.05%	3.41%	0.39%	0.08%	3.49%	3.29%
210045	McCready Foundation, Inc.	6.84%	10.27%	9.66%	8.10%	8.88%	0.05%	8.93%	3.39%	0.68%	9.61%	9.07%
210048	Howard County General Hospital	5.73%	5.21%	7.09%	5.25%	6.17%	0.05%	6.22%	0.66%	0.13%	6.35%	5.99%
210049	Upper Chesepeake Medical Center	5.47%	5.90%	6.60%	5.57%	6.09%	0.05%	6.14%	1.00%	0.20%	6.34%	5.98%
210051	Doctors Community Hospital	8.25%	10.88%	9.99%	9.61%	9.80%	0.05%	9.84%	0.43%	0.09%	9.93%	9.38%
210054	Southern Maryland Hospital	7.39%	9.49%	8.23%	8.61%	8.42%	0.05%	8.47%	0.68%	0.14%	8.60%	8.12%
210055	Laurel Regional Hospital	11.07%	12.63%	10.69%	11.76%	11.22%	0.05%	11.27%	0.28%	0.06%	11.33%	10.70%
210056	Good Samaritan Hospital	5.72%	5.80%	5.97%	5.90%	5.93%	0.05%	5.98%	1.41%	0.28%	6.26%	5.91%
210057	Shady Grove Adventist Hospital	6.60%	6.66%	7.97%	7.18%	7.58%	0.05%	7.63%	2.84%	0.57%	8.19%	7.74%
210058	James Lawrence Kernan Hospital	6.30%	6.22%	2.37%	6.58%	6.58%	0.00%	6.58%	0.50%	0.10%	6.68%	6.31%
210060	Fort Washington Medical Center	9.60%	14.20%	10.17%	13.30%	11.74%	0.05%	11.78%	1.40%	0.28%	12.06%	11.39%
210061	Atlantic General Hospital	5.64%	5.48%	6.27%	5.58%	5.93%	0.05%	5.97%	1.36%	0.27%	6.25%	5.90%
	STATE-WIDE	6.74%	7.39%	7.45%	7.21%	7.35%	0.05%	7.39%	2.17%	0.43%	7.83%	7.39%

Appendex VIII

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

September 28, 2009

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215-2299

Dear Chairman Young:

On behalf of the 67 members of the Maryland Hospital Association (MHA), this letter is written regarding the work of the HSCRC Patient Financial Assistance and Debt Collection Work Group. At the outset, I want to emphasize that Maryland hospitals are committed to ensuring that financial assistance opportunities are broadly known, understood, and readily available. Maryland has been among the more progressive states in adopting laws, regulations, and voluntary guidelines relating to hospital financial assistance and collection policies. And, we believe Maryland should continue to be among the top innovators in policy making around this topic.

Our comments regarding the Work Group recommendations focus on the following four issues:

Financial Assistance Eligibility Thresholds

The recommendation contained in the report specifies: 1) free care be available to uninsured patients with gross household income up to 200 percent of the federal poverty level (FPL); 2) discounts be available to uninsured patients, with household income up to 300 percent of FPL; and 3) hospitals can request a lower standard (no lower than 150 percent of FPL), but must demonstrate to the HSCRC that 200 percent would yield undue financial hardship.

As you know, the General Assembly enacted legislation during the 2009 session that addressed this issue. A uniform 200 percent level for free care was specifically considered and rejected by the legislature during the session. It was noted that going to 200 percent of FPL would be higher than the median income in certain counties and would result in a significant percentage of the service area of some hospitals being eligible for free care.

Instead, HB 1069 (attached) states in Section 19-214.1 (a) (2) and (3) of the Health General Article:

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

(I) Free medically necessary care to patients with family income at or below 150% of the federal poverty level; and

(II) Reduced-cost medically necessary care to low-income patients with family income above 150% of the federal poverty level, in accordance with the mission and service area of the hospital.

(3) (I) The Commission by regulation may establish income thresholds that are higher than under paragraph (2) of this subsection.

(II) In establishing income thresholds that are higher than those in paragraph (2) of this subsection for a hospital, the Commission shall take into account:

1. *The patient mix of the hospital;*
2. *The financial condition of the hospital;*
3. *The level of bad debt experienced by the hospital; and*
4. *The amount of charity care provided by the hospital."*

The intent is clear from this language that the Commission would be making the determination of whether a given hospital should be required to provide free care above the 150% minimum on a case by case/individual hospital basis. The Commission was to decide the issue based on the individual characteristics of the hospital and take into account very specific facts related to the individual hospital. The recommendation contained in the report is not consistent with or in accordance with the legislation. The burden of justifying that a higher level is appropriate for a given hospital rests with the Commission. The statute did not place the responsibility on hospitals to justify going below the 200 percent level for free care.

Further, the Commission put into place a "maintenance of effort" requirement in the regulations promulgated in June to protect against hospitals who had more generous financial assistance polices dropping to the 150 percent level contained in the statute. And, the new policy on the allocation of "bad debt" and "charity care" provides an additional incentive for hospitals to adopt more generous financial assistance policies and report it more accurately.

For the above reasons we ask that the Commission comply with the governing statute and reject the recommendation contained in the report.

Medical Hardship

The recommendation requires hospitals to adopt a medical hardship policy that limits medical debt to 25 percent of household income for uninsured or underinsured patients with income up to 500 percent of the FPL. This recommendation is problematic for several reasons. It creates a disincentive for individuals with substantial income (up to 500 percent of FPL) not to purchase insurance; it allows individuals to shelter all assets; and provides an incentive for carriers to offer less than adequate limited benefit plans and take advantage of the predicted benefits provided by the hospital.

Further, because there are so many variables that go into the equation of what constitutes a "medical hardship" it is very difficult to establish one uniform standard, e.g., size of the bill relative to income, ability to pay, family size, ongoing medical expenses, median income for the hospital's service area, etc.

An alternative approach would be to simply require each hospital to develop a policy for medical hardship for financial assistance and submit it to the Commission. Each hospital would be able to balance available hospital resources against the needs of its community and the hospital's mission. And, because most states do not have a uniform policy relating to medical hardship, Maryland would continue to be among the innovators of policy making in this area.

Reporting Requirements

Maryland's unique hospital rate-setting system provides tremendous transparency and public accountability. Maryland hospitals must publicly report and make available a vast array of information and data. Over years, this has been a true benefit of our system.

Today, however, hospitals are being barraged with mandates to report additional information from many government agencies.

The recommendations in the report add yet another layer of detailed reporting that is of questionable need or value. As you recall, last December, hospitals were required to complete a detailed survey on credit and collection policies (attached); in January new regulations were adopted requiring additional annual reporting to the HSCRC on credit and collection policies and activities (attached); in March the HSCRC required hospitals to conduct special audits on financial assistance policies; and in June hospitals were required to implement new requirements relating to the hospital patient financial information sheet (attached). We believe the HSCRC already has sufficient detailed data on this issue and would have the ability to conduct special audits or surveys if an issue arose.

It also is unclear why the additional information is needed. The current regulations require hospitals to submit to the Commission their policies on the collection of debts owed by patients and require active oversight by the hospital of any contract for collection of debts on behalf of the patient; the uniform financial assistance application already details what documentation can be required by the hospital for individuals to qualify for financial assistance; and one of the other recommendations contained in the report will require all financial assistance and credit and collection policies to be reviewed and approved by the hospital's board of directors every three years and when changed.

We would request that the additional data reporting requirements be eliminated.

Process

HB 1069 required the HSCRC to establish a work group on patient financial assistance and debt collection. The work group was required to report its findings and recommendations to the Governor and the General Assembly on or before October 1, 2009.

The process and work product was unfortunately driven, almost entirely, by staff and consultants to the Commission. Examples include: a no-bid contract was awarded to Hilltop Consulting; the scope of the consultant's work was defined by Commission staff before the work group was convened; lengthy, detailed materials often were provided just 24 hours before the meetings; no votes were taken on any of the recommendations; no process was available to appeal a decision if there was disagreement with a recommendation; and, no review and approval of the

recommendations by the HSCRC Commissioners is to occur prior to submission to the Governor and General Assembly. Further, despite a commitment to have a collection agency representative on the work group, the decision was unilaterally made not to include them as a member. They were instead afforded a three-minute public comment opportunity at one of the meetings.

We appreciate the opportunity to comment on these recommendations. Please contact me if you need additional information or want to further discuss these issues.

Sincerely,

Pegeen A. Townsend
(On behalf of The Maryland Hospital Association)

Attachments
cc: HSCRC Commissioners:
Kevin J. Sexton, Vice Chair
Joseph R. Antos, Ph.D.
Trudy R. Hall, M.D.
Steven B. Larsen
C. James Lowthers
Herbert S. Wong, Ph.D.
Robert Murray, HSCRC
Stephen Ports, HSCRC

CHAPTER 311

(House Bill 1069)

AN ACT concerning

Health Services Cost Review Commission – Financial Assistance and Debt Collection Policies

FOR the purpose of requiring ~~each hospital~~ the Health Services Cost Review Commission to require certain hospitals in the State to develop a financial assistance policy for providing free care and reduced–cost care to certain patients; requiring a hospital to post a certain notice in its billing office; requiring each hospital to develop an information sheet that meets certain requirements; requiring the ~~Health Services Cost Review~~ Commission to establish uniform requirements for the information sheet and review each hospital's implementation of and compliance with certain requirements; requiring each hospital to ensure the availability of staff with certain training; altering requirements for each hospital's submission of a policy on debt collection; requiring the policy to meet certain requirements; requiring the Commission to review each hospital's implementation of and compliance with the policy and requirements; authorizing the Commission to impose a certain fine under certain circumstances and to consider certain items before imposing a fine; altering the requirements for regulations establishing alternative methods for financing certain costs of care; requiring the Commission to establish a workgroup on patient financial assistance and debt collection for ~~a certain purpose~~ certain purposes; requiring the workgroup to report certain findings and recommendations on or before a certain date; requiring the Commission to study, make recommendations, and report on incentives for hospitals to provide free and reduced–cost care to certain patients; ~~requiring the Office of the Attorney General, in consultation with certain entities and persons, to study, make recommendations, and report on the use of liens and the legal rate of interest on judgments for certain hospital bills;~~ and generally relating to the Health Services Cost Review Commission and hospital financial assistance and debt collection policies.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214(b) and 19–214.1
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY adding to
Article – Health – General
Section 19–214.2 and 19–214.3

Annotated Code of Maryland
(2005 Replacement Volume and 2008 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.

(b) The Commission may adopt regulations establishing alternative methods for financing the reasonable total costs of hospital uncompensated care provided that the alternative methods:

(1) Are in the public interest;

(2) Will equitably distribute the reasonable costs of uncompensated care;

(3) Will fairly determine the cost of reasonable uncompensated care included in hospital rates;

(4) Will continue incentives for hospitals to adopt **FAIR,** efficient**,** and effective credit and collection policies; and

(5) Will not result in significantly increasing costs to Medicare or the loss of Maryland's Medicare Waiver under § 1814(b) of the Social Security Act.

19–214.1.

~~(a) Each hospital in the State shall develop a financial assistance policy for providing [free and reduced–cost care to low–income] TO patients who lack health care coverage OR WHOSE HEALTH CARE COVERAGE DOES NOT PAY THE FULL COST OF THE HOSPITAL BILL:~~

(A) (1) THE COMMISSION SHALL REQUIRE EACH ACUTE CARE HOSPITAL IN THE STATE 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:

~~(1)~~ (I) **FREE MEDICALLY NECESSARY CARE TO PATIENTS WITH FAMILY INCOME AT OR BELOW 150% OF THE FEDERAL POVERTY LEVEL; AND**

~~(2)~~ (II) **REDUCED–COST MEDICALLY NECESSARY CARE TO LOW–INCOME PATIENTS WITH FAMILY INCOME ABOVE 150% OF THE FEDERAL POVERTY LEVEL, IN ACCORDANCE WITH THE MISSION AND SERVICE AREA OF THE HOSPITAL.**

(3) *(I)* THE COMMISSION BY REGULATION MAY ESTABLISH INCOME THRESHOLDS HIGHER THAN THOSE UNDER PARAGRAPH (2) OF THIS SUBSECTION.

(II) IN ESTABLISHING INCOME THRESHOLDS THAT ARE HIGHER THAN THOSE UNDER PARAGRAPH (2) OF THIS SUBSECTION FOR A HOSPITAL, THE COMMISSION SHALL TAKE INTO ACCOUNT:

1. THE PATIENT MIX OF THE HOSPITAL;

2. THE FINANCIAL CONDITION OF THE HOSPITAL;

3. THE LEVEL OF BAD DEBT EXPERIENCED BY THE HOSPITAL; AND

4. THE AMOUNT OF CHARITY CARE PROVIDED BY THE HOSPITAL.

(b) A hospital shall post a notice in conspicuous places throughout the hospital, **INCLUDING THE BILLING OFFICE,** describing the financial assistance policy and how to apply for free and reduced–cost care.

(c) The Commission shall:

(1) Develop a uniform financial assistance application; and

(2) Require each hospital to use the uniform financial assistance application to determine eligibility for free and reduced–cost care under the hospital's financial assistance policy.

(d) The uniform financial assistance application:

(1) Shall be written in simplified language; and

(2) May not require documentation that presents an undue barrier to a patient's receipt of financial assistance.

(e) **(1)** Each hospital shall [establish a mechanism to provide the uniform financial assistance application to patients who do not indicate public or private health care coverage] **DEVELOP AN INFORMATION SHEET THAT:**

(I) DESCRIBES THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY;

(II) DESCRIBES A PATIENT'S RIGHTS AND OBLIGATIONS WITH REGARD TO HOSPITAL BILLING AND COLLECTION UNDER THE LAW;

(III) PROVIDES CONTACT INFORMATION FOR THE INDIVIDUAL OR OFFICE AT THE HOSPITAL THAT IS AVAILABLE TO ASSIST THE PATIENT, THE PATIENT'S FAMILY, OR THE PATIENT'S AUTHORIZED REPRESENTATIVE IN ORDER TO UNDERSTAND:

1. THE PATIENT'S HOSPITAL BILL;

2. THE PATIENT'S RIGHTS AND OBLIGATIONS WITH REGARD TO THE HOSPITAL BILL;

3. HOW TO APPLY FOR FREE AND REDUCED–COST CARE; AND

4. HOW TO APPLY FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND ANY OTHER PROGRAMS THAT MAY HELP PAY THE BILL;

(IV) PROVIDES CONTACT INFORMATION FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM; AND

(V) INCLUDES A STATEMENT THAT PHYSICIAN CHARGES ARE NOT INCLUDED IN THE HOSPITAL BILL AND ARE BILLED SEPARATELY.

(2) THE INFORMATION SHEET SHALL BE PROVIDED TO THE PATIENT, THE PATIENT'S FAMILY, OR THE PATIENT'S AUTHORIZED REPRESENTATIVE:

(I) BEFORE DISCHARGE;

(II) WITH THE HOSPITAL BILL; AND

(III) ON REQUEST.

(3) THE HOSPITAL BILL SHALL INCLUDE A REFERENCE TO THE INFORMATION SHEET.

(4) THE COMMISSION SHALL:

(I) ESTABLISH UNIFORM REQUIREMENTS FOR THE INFORMATION SHEET; AND

(II) REVIEW EACH HOSPITAL'S IMPLEMENTATION OF AND COMPLIANCE WITH THE REQUIREMENTS OF THIS SUBSECTION.

[(f) (1) Each hospital shall submit to the Commission the hospital's policy on the collection of debts owed by patients who qualify for reduced–cost care under the hospital's financial assistance policy.

(2) On or before July 1, 2006, the Commission shall report, in accordance with § 2–1246 of the State Government Article, to the House Health and Government Operations Committee and the Senate Finance Committee on the details of the policies submitted to the Commission under paragraph (1) of this subsection.]

(F) EACH HOSPITAL SHALL ENSURE THE AVAILABILITY OF STAFF WHO ARE TRAINED TO WORK WITH THE PATIENT, THE PATIENT'S FAMILY, AND THE PATIENT'S AUTHORIZED REPRESENTATIVE IN ORDER TO UNDERSTAND:

(1) THE PATIENT'S HOSPITAL BILL;

(2) THE PATIENT'S RIGHTS AND OBLIGATIONS WITH REGARD TO THE HOSPITAL BILL;

(3) HOW TO APPLY FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND ANY OTHER PROGRAMS THAT MAY HELP PAY THE HOSPITAL BILL; AND

(4) HOW TO CONTACT THE HOSPITAL FOR ADDITIONAL ASSISTANCE.

19–214.2.

(A) EACH HOSPITAL SHALL SUBMIT TO THE COMMISSION, AT TIMES PRESCRIBED BY THE COMMISSION, THE HOSPITAL'S POLICY ON THE COLLECTION OF DEBTS OWED BY PATIENTS.

(B) THE POLICY SHALL:

(1) PROVIDE FOR ACTIVE OVERSIGHT BY THE HOSPITAL OF ANY CONTRACT FOR COLLECTION OF DEBTS ON BEHALF OF THE HOSPITAL;

(2) PROHIBIT THE HOSPITAL FROM SELLING ANY DEBT;

~~**(3) PROHIBIT THE HOSPITAL FROM PLACING A LIEN ON A PRIMARY RESIDENCE;**~~

~~(4)~~ (3) PROHIBIT THE CHARGING OF INTEREST ON ~~OVERDUE BILLS~~ BILLS INCURRED BY SELF–PAY PATIENTS BEFORE A COURT JUDGMENT IS OBTAINED;

~~(5)~~ (4) DESCRIBE IN DETAIL THE CONSIDERATION BY THE HOSPITAL OF PATIENT INCOME, ASSETS, AND OTHER CRITERIA;

~~(6)~~ (5) DESCRIBE THE HOSPITAL'S PROCEDURES FOR COLLECTING A DEBT; AND

~~(7)~~ (6) DESCRIBE THE CIRCUMSTANCES IN WHICH THE HOSPITAL WILL SEEK A JUDGMENT AGAINST A PATIENT.

(C) THE COMMISSION SHALL REVIEW EACH HOSPITAL'S IMPLEMENTATION OF AND COMPLIANCE WITH THE HOSPITAL'S POLICY AND THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION.

19–214.3.

(A) IF A HOSPITAL KNOWINGLY VIOLATES ANY PROVISION OF § 19–214.1 OR § 19–214.2 OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER THIS SUBTITLE, THE COMMISSION MAY IMPOSE A FINE NOT TO EXCEED $50,000 PER VIOLATION.

(B) BEFORE IMPOSING A FINE, THE COMMISSION SHALL CONSIDER THE APPROPRIATENESS OF THE FINE IN RELATION TO THE SEVERITY OF THE VIOLATION.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall establish a workgroup on patient financial assistance and debt collection. The workgroup shall review:

(1) the need for uniform policies among hospitals relating to patient financial assistance and debt ~~collection and shall consider the following elements for inclusion in~~ collection, including as elements within any uniform policies:

~~(1)~~ (i) income thresholds and any special treatment of disability and pension income;

~~(2)~~ (ii) asset thresholds and treatment of various types of assets;

(iii) use of liens to enforce collection of a debt;

~~(3)~~ (iv) collection procedures;

~~(4)~~ (v) establishment of guardianship;

~~(5)~~ (vi) use of judgments to collect debts; and

~~(6)~~ (vii) patient education and outreach to inform patients of the availability of financial assistance with their bills;

(2) the desirability of applying any uniform policies to private psychiatric and chronic care hospitals; and

(3) the desirability of altering the legal rate of interest on a judgment to collect a hospital debt.

(b) The workgroup shall report its findings and recommendations, including recommendations for legislation, to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on or before October 1, 2009.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall study and make recommendations on incentives for hospitals to provide free and reduced–cost care to patients without the means to pay their hospital bills.

(b) The Commission shall report its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on or before October 1, 2009.

SECTION 4. AND BE IT FURTHER ENACTED, That:

~~(a) The Office of the Attorney General, in consultation with the American Bar Association, Legal Aid, the University of Maryland Law School, and other interested persons, shall study and make recommendations on the use of liens and the legal rate of interest on a judgment for a hospital bill of a patient without health~~

~~insurance. The study shall take into account the use of liens and the legal rate of interest on other types of debt.~~

~~(b) The Judiciary shall report its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on or before October 1, 2009.~~

~~SECTION 5. AND BE IT FURTHER ENACTED, That~~ this Act shall take effect June 1, 2009.

Approved by the Governor, May 7, 2009.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Donald A. Young, M.D.
Chairman

Joseph R. Antos, Ph.D.
Raymond J. Brusca, J.D.
Trudy R. Hall, M.D.
C. James Lowthers
Kevin J. Sexton
Herbert S. Wong, Ph.D.

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

John J. O'Brien
Deputy Director
Research and Methodology

HEALTH SERVICES COST REVIEW COMMISSION
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Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

URGENT

MEMORANDUM

TO: Chief Financial Officers

FROM: Robert Murray, Executive Director RMurray

DATE: December 8, 2008

RE: Hospital Credit and Collection Policy Survey

As per the provisions of Health-General Article, §19-214.1, your hospital is directed to complete HSCRC's Hospital Credit and Collection Survey (attached) and to submit a copy of your hospital's credit and collection policy to the HSCRC. For your convenience, the survey will be placed on the HSCRC's website. A hard copy of the survey and the credit and collection policy may be submitted to me or may be e-mailed to Amanda Greene at agreene@hscrc.state.md.us.

The survey and a copy of your hospital's credit and collection policy will be due in the HSCRC's offices on or before December 22, 2008.

If you have any questions concerning the above, you may contact Dennis N. Phelps, Associate Director-Audit & Compliance at (410) 764-2565.

HSCRC Hospital Credit and Collection Policy Survey

GENERAL INFORMATION

Hospital Name:

Contact Person:
Contact Number:
Contact Email:

INTERNAL HOSPITAL COLLECTION POLICY

A1	If a patient gives no response to the hospital's collection efforts, when does the hospital refer the account to a collection agency (in days)?	45-59	60 -89	90-119	120+
		4	11	15	16
		YES	NO		
A2	If a patient agrees to a reasonable collection plan with the hospital, does this stop the timing cycle for referring a patient's account to a collection agency?	45	1		
		YES	NO		
A3	Does your hospital charge interest for payment plans for accounts in active AR? If yes, please provide detail including rates and terms.	0	46		
		YES	NO		
A4	Does your hospital bill include the following or a similar statement? "This bill is only for hospital services. You should expect a separate bill from your physician."	32	14		
		YES	NO		
A5	Do you have a single phone number on the hospital bill that a patient can call to get their questions answered?	46	0		
		YES	NO		
A6	If a patient has a history of previous non-payment, is the credit and collection process different? (e.g., immediate write-off to bad debt, commence full billing cycle?)	9	37		
		YES	NO		
A 7	If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's internal collection policy different (yes/no)? If yes, please explain.	21	25		

EXTERNAL COLLECTION POLICY

B1 How is the account classified once it moves to a collection agency? (e.g., bad debt?)

45 = Bad Debt 1= AR Fully Reserved

B2 While a debt is at a collection agency, is the debt permitted to be noted on a patient's credit report? If yes, please provide details (when noted on credit report, how long, etc.).

YES	NO
30	16

B3 Who determines when an account should be considered uncollectible? (i.e., collection agency? Hospital?) After what period of time? (in days)

Hospital	Collection Agency	Both
18	25	3

B4 When an account is determined to be uncollectible, how does the hospital classify the account? (e.g., bad debt?)

45 = Bad Debt 1 = Charity

B5 Who determines whether or not a patient has assets available to satisfy outstanding debt? (i.e., collection agency? Hospital?)

Hospital	Collection Agency	Both
13	24	14

B6 **Is your collection agency authorized to pursue legal judgements? (e.g., garnishment of wages, Lien on assets - undertaken by hospital? Collection agency?)** If assets are determined to be available and sufficient to satisfy either in part or in whole the outstanding debt and the patient has not responded to phone calls and letters, what steps are taken? Please provide details if necessary.

No Answer	YES	NO
3	22	21

B7 Does your hospital charge interest for accounts in bad debt collections? If yes, please provide detail including rates and terms.

YES	NO
11	34

B8 In what circumstances will the hospital execute a legal judgment? Please provide example.

Details

		No Answer	YES	NO
B9	If your hospital determines that a patient qualifies for reduced-cost care under the hospital's financial assistance policy, is the hospital's external collection policy different (yes/no)? If yes, please explain.	1	8	36

OTHER CREDIT/COLLECTION INFORMATION

		YES	NO	Amount Spent ($)	Average Amount Spent$
C1	Does your hospital expend funds to enroll patients eligible for insurance coverage in such programs? If yes, please provide names of programs or products? If yes, how much does your hospital spend (total amount)?	37	9	$9,082,967.81	$197,455.82

C2	What percentage of cases get turned over to a bad debt collection agency? Please use the following formula to calculate: **# of cases to bad debt collections/total number of cases**		**Average % of cases sent to Bad Debt Collection Agency**	
			17.41%	out of 37 hospitals
C3	What percentage of cases go to legal action? Please use the following formula to calculate: **# of cases to legal action/total number of cases**	**# of hospitals less than 1%**	**Average % of cases referred for legal action**	
		10	5.03%	out of 31 hospitals

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10.37.10.26

.26 Differentials.

A. Hospital Information Sheet.

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

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

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

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

(i) The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill;

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

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

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

(e) Includes a statement that physician charges are not included in the hospital bill and are billed separately.

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

(a) Before discharge;

(b) With the hospital bill; and

(c) On request.

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

(4) The Commission shall:

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

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

A-1. Hospital Credit and Collection Policies.

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

(2) The policy shall:

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

(b) Prohibit the hospital from selling any debt;

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

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

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

(f) Describe the circumstances in which the hospital will seek a judgment against a patient.

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

B. Working Capital Differentials—Payment of Charges.

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

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

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

(c) Outstanding charges shall be calculated by an amount equal to the hospital's current average daily payment by the payer, multiplied by the hospital's and third-party payer's processing and payment time.

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

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

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

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

(4) Hospital Billing Responsibilities.

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

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

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

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

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

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

(5) Hospital Financial Assistance Responsibilities.

(a) On or before June 1, 2009, each hospital shall develop a written financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage. The financial assistance policy shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below 150 percent of the federal poverty level; and

(ii) Reduced-cost, medically necessary care to low-income patients with family income above 150 percent of the federal poverty level, in accordance with the mission and service area of the hospital.

(b) A hospital whose current financial assistance policy, that is, as of May 8, 2009, provides for free or reduced-cost medical care to patients at income thresholds higher than the 150 percent level set forth above may not reduce that income threshold.

(c) A notice shall be posted in conspicuous places throughout the hospital, including the billing office, describing the financial assistance policy and how to apply for free and reduced-cost care.

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

(e) Each hospital shall establish a mechanism to provide the Uniform Financial Assistance Application to patients who do not indicate public or private health care coverage.

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

HEALTH SERVICES COST REVIEW COMMISSION
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Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

To: All CFOs Maryland Acute Care Hospitals

From: Robert Murray, Executive Director

Date: May 21, 2009

Re: Maryland Hospital Patient Information Sheet

According to Health-General §19-214.1(e), Maryland's acute care hospitals must provide a patient information sheet to patients being discharged from the hospital. The HSCRC has developed guidelines for assisting hospitals in developing their patient information sheet. The requirement has a June 1, 2009 effective date, which all acute hospitals must be prepared to meet.

Click here for the Patient Information Sheet

In order to fulfill the requirements of the statute, the HSCRC will require that all acute care hospitals provide a copy of their information sheet to the HSCRC by June 19, 2009. It should be sent to Amanda Greene at the following email address: agreene@hscrc.state.md.us .

If you have any questions regarding the enclosed information, please contact Steve Ports or Amanda Greene at 410-764-2605.

Maryland Hospital Patient Information Sheet

Frequently Asked Questions

1. **What must be provided to patients in the information sheet by acute care hospitals required under Health-General §19-214.1(e) and Maryland regulations, COMAR 10.37.10.26 (6)?**

    a. Description of the hospital's financial assistance policy;

    b. Description of the patient's rights and obligations with regard to hospital billing and collection under the law;

    c. Contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative with

        i. the patient's hospital bill;

        ii. the patient's rights and obligations; and

        iii. how to apply for free and reduced care.

    d. Contact information for the Maryland Medical Assistance Program; and

    e. A statement that physician charges are not included in the hospital bill and are billed separately.

2. **When must this sheet be available?**

    a. June 1, 2009, it must be ready to give to patients before discharge, along with the hospital bill, and upon request.

        i. Before discharge means the form can be provided to patients as part of the registration packet.

3. **Does the form have to be provided with every billing statement mailed to the patient?**

    a. It is the current position of the HSCRC that the information sheet be provided, at a minimum, with the initial bill; however, this position is subject to further review. If this position changes, hospitals will be given advance notice of any such change.

4. **Does the information sheet requirement apply only to bills for inpatient services?**

a. Yes. At this time, it refers to inpatient services. The Commission will study the feasibility of applying this requirement to outpatient bills as well. If this policy changes, hospitals will be given advance notice. The Commission expects that hospitals that have been providing an information sheet to patients receiving outpatient services in the past should continue to do so.

b. An information sheet is not required to be used by non-acute care, psychiatric and chronic care hospitals at this time. The Commission will be studying whether an information sheet should be provided by these facilities in the future.

5. **Do our patient information sheets have to be identical to the one developed by the HSCRC?**

    a. No. The HSCRC information sheet is a sample sheet designed to assist hospitals in understanding the elements that should be included. It is incumbent on hospitals to comply with the provisions specified under Question #1.

    b. The HSCRC will be requiring hospitals to submit their information sheets in place in mid-June (2009). The HSCRC will review these sheets for compliance with the law, commonality, and reasonableness. Following this review, the Commission may provide more specific requirements. Hospitals will be provided advance notice of any changes.

6. **Is a verification of receipt (patient signoff) necessary?**

    a. At this time, it will not be required. The HSCRC will consider this as part of the review referred to under Question #5b.

7. **In what language must the form be provided?**

    a. At a minimum, English and Spanish.

HSCRC Guidelines for Developing the Maryland Hospital Patient Information Sheet

A patient information sheet is required to be provided to patients and their representatives at discharge, with hospital bills, and on request

Hospital Financial Assistance Policy: (This is intended to inform patients about the hospital's financial assistance policy. Give a 3 – 10 line description)

Example:

- This hospital provides emergency or urgent care to all patients regardless of ability to pay.
- You are receiving this information sheet because under Maryland law, this hospital must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance with the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you are low-income.
- This hospital meets or exceeds the legal requirement by providing financial assistance based on: (give specifics of your financial assistance policy for free or reduced-cost care; i.e. income level, family size, etc., stress the importance of collecting correct information).

Patients' Rights and Obligations

Patients' Rights: (This section is intended to inform patients of their right to receive assistance in paying their hospital bills)

Example:

- Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.
- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance (see contact information below).
- You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the state and federal governments that pays the full

cost of health coverage for low-income individuals who meet certain criteria (see contact information below).

Patients' Obligations: (This section is intended to inform patients of their obligation to pay the hospital bill and to provide complete and accurate information to the hospital)

Example:

- For those patients with the ability to pay their bill, it is the obligation of the patient to pay the hospital in a timely manner.
- This hospital makes every effort to see that patient accounts are properly billed, and patients may expect to receive a uniform summary statement within 30 days of discharge. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office promptly, (give phone number) to discuss this matter.
- If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts: (this section is intended to provide easy access for patients to contact the hospital, Medical Assistance, etc.)

Example:

- If you have questions about your bill, please contact the hospital business office at: (give phone number.) A hospital representative will be glad to assist you with any questions you may have.
- If you wish to get more information about or apply for the hospital's financial assistance plan, you may call (give phone number) or download the uniform financial assistance application from the following link: http://www.hscrc.state.md.us/consumers_uniform.cfm

- If you wish to get more information about or apply for Maryland Medical Assistance you may contact your local Department of Social Services by phone 1-800-332-6347; TTY: 1-800-925-4434; or internet www.dhr.state.md.us .

Physician Services

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement.

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WARREN S. OLIVERI, JR. PRESIDENT

SEP 29 '09 PM 2:57

September 28, 2009

Robert Murray
Executive Director
Health Services Cost Review
Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Health Services Cost Review Commission Recommendations regarding Financial Assistance and Debt Collection Policies

Dear Mr. Murray:

I submit this letter regarding the final recommendations of the Health Services Cost Review Commission's(HSCRC) Financial Assistance and Debt Collection Policies and its Report to Governor Martin O'Malley. I served as a member of the Workgroup that was formed after the passage of HB 1069 and my role was primarily to be a voice for consumers. I am the Senior Staff attorney for Consumer Law at the Legal Aid Bureau. The Legal Aid Bureau, Inc. represents low income residents of Maryland in the areas of housing, consumer, administrative benefits, family law, and children in need of assistance that are abused or neglected.

Low income consumers come to the Bureau's offices throughout Maryland for many different issues associated with consumer finance and contracts. Medical bills are often a part of our clients' financial problems due to a lack of health insurance or inadequate health insurance that results in lawsuits, judgments, garnishments and bankruptcy. Further, failure of a hospital to properly bill medical assistance, sending a bill to debt collection, or failure to offer financial assistance when appropriate, are problems that also affect Bureau clients and consumers at large.

Uniform Policies

In general, hospitals should be required to adopt minimum uniform policies that cover financial assistance – both free and reduced care based on income, assets and circumstances – and debt collection. Uniformity is fundamental to the interests of all parties that give, receive and pay for hospital bills. While the service areas of Maryland hospitals vary in terms of income levels and cost of living, these are variables that can change over time depending on economic circumstances. Setting uniform policies from the start will create a state wide standard that hospitals and patients can rely on, negate the need for changing policies by geographic location when economic situations change, and avoid the possibility of patients having to move from area to area for more favorable economic terms. From the discussions of the Workgroup and interaction with other acute care hospitals in cases brought to me by Legal Aid Bureau, Inc. clients, it is apparent that hospitals vary in their approach in financial assistance and debt collection.

I. Financial Assistance Policies

The minimum income levels for free care should be ***at least*** 200% of poverty to those without insurance or those that lack sufficient insurance and at least up to 300% of poverty for reduced cost medical services. Those who are eligible for reduced cost services should only have to pay a percentage of the cost of the service. These levels follow the legislative intent of HB1069. Sixty percent of Maryland Hospitals are already offering free care to those households below 200% of poverty. Further, if this policy was not financial feasible for a hospital, then regulations could permit hospitals to step back from the requirement if it was unduly burdensome.

It is also important to note that Maryland's cost of living is higher than all but a hand full of other states, which is due, in part, to Maryland's position as the country's richest state. High living costs are unlikely to change because of Maryland's geographic location and high income rates due to a highly trained workforce.

Several reports of note that were discussed in an article by the Capital News Service, *Federal Funding Shows Poverty May be on the Rise in* Maryland by Erika Woodward, May 6, 2009 cites to a report by the Center on Budget and Policy Priorities. That report speaks to the fact that Maryland was one of the top ten states in the last twenty years to experience an income inequality between economic classes. Also in that article is a finding by the Center on Women's Welfare at the University of Washington that the cost of groceries in Maryland is between 10 and 21 percent higher than the national average. It is generally accepted that the cost of housing in Maryland is far more than the national average in both the rental and purchase market. According to a very recent report of the Census Bureau, half of Maryland renters were spending at least ... "30 percent or more of their monthly household incomes – before taxes – on rent last year...Forty percent of homeowners with mortgages were doing the same." Baltimore Sun, *For more, 'affordable' isn't so* by Jamie Smith Hopkins, September 28, 2009. Further, according to the Census Bureau Guidelines as of January of 2009, Maryland's median family income was among the

top four of all states.
http://www.usdoj.gov/ust/eo/bapcpa/20090315/bci_data/median_income_table.htm
While this shows a population high in income, basic living costs rise according to what the market will bear. The federal poverty guidelines are established looking at the United States as a whole but the impact of Maryland's living cost must be taken into account when considering free and reduced care for services because the same amount of income simply does not go as far in Maryland as in most other states.

Refunds to Patients Eligible for Financial Assistance

Within this topic, the Workgroup discussed refunding to patients money collected from those patients approved for free care. There appeared to be objections to this concept from representatives of hospitals and health systems. This was somewhat resolved with the compromise that money collected would only be returned if it was above $25.00. It is only correct that when a mistake is made, credit is given back to the consumer. Following the same theory, if a judgment is entered, that should be vacated, when the patient is deemed eligible for free care.

A patient should have a three year time period from the date of service to apply for free care. The three year period corresponds with this State's general statute of limitations of three years for contracts. It is necessary when a person has qualified and is granted financial assistance to refund money the consumer has paid and also ensure that the judgment, that was improperly granted, be vacated. If there is no longer a basis for the judgment, the creditor must take the proper steps to acknowledge the debt is no longer owed. Allowing a judgment to remain that is an empty shell could cause tremendous credit issues for the consumers, is unjust, and simply a bad business practice for hospitals.

Presumptive Eligibility for Free Care

Consumers who are already deemed eligible for means tested social services programs, should be presumptively eligible for free care. This proposal recognizes the fact that these consumers have already been vetted for income and asset eligibility and this frees up hospital resources from having to undertake a second eligibility investigation.

Reduced Cost Care for Medically Necessary Services and Medical Hardship

Consumers would benefit from the proposals made on both these topics including discounting costs for household incomes of ***at least*** 300% poverty, payment plans that are reasonable in that they take into account the amount of the bill, the amount of the household income, the extent of the medical hardship and/or other non-hospital medical debt, and a limitation of payment of the total bill if it exceeds 25% of household income (for medical indigence).

Assets

It is beneficial for consumers to have a minimum level of uniform assets that hospitals will exempt from consideration when performing an asset assessment. Assets that should be excluded are:

- Consideration of social security income, veterans' benefits, disability income, and child support. Thus far comments have proposed treating all income as an asset and not excluding income by type. As to income types, without proposing a specific exclusion by amount other than the level of federal poverty guidelines, it is worthwhile to note that federal and Maryland law exempts all social security income, federal benefits, federal pensions, state pensions, and child support, from collection by a judgment creditor.

- A person's principal residence from the consideration of available assets. In comments that the Maryland Hospital Association/Hospital submitted early in the Workgroup process, the MHA/Hospital proposed excluding a patient's principal residence in a determination of assets while the HSCRC proposal would exclude up to $150,000 of a person's principal residence. The amount of $150,000 is too low. Placing a value on the amount of the exclusion is only fair if there is a provision to increase the amount of the exclusion on a yearly basis, when Maryland's home values rise. While most real estate in Maryland has lost value due to the present economic downturn, when the economy recovers, home values in this State will again begin to grow and limiting the amount of this asset could soon become outdated. Further, the $150,000 amount will immediately adversely affect that live in many counties and Baltimore City because median home values in those locations are already above that dollar amount.

- In addition to the items listed above, adopt the HSCRC's other assets and resolve that those are the only items that can be considered as an asset. The need for such a list is highlighted by a very recent collection case that appeared at the one of the offices of the Legal Aid Bureau, Inc. A person residing in Montgomery County, who receives social security and Medicare, was sued for the uncovered 20% portion of the hospital bill by a hospital located in Montgomery County. When the collection attorney was asked why the patient was not offered financial assistance, the response was that the patient did not qualify for financial assistance because he owed a home, though they acknowledged it was owned as tenants by the entireties, and the patient had available credit on a credit card. The income of the patient and his spouse fell within Legal Aid Bureau income guidelines. Both the patient and his spouse only received social security as a source of income. Thus in this situation you have an elderly couple living on social security. The home was counted as an asset as was credit on a credit card. Already stated is that a principal residence should not be counted as an asset but also the ability to access credit - and therefore go into further debt - should not be counted as an asset.

Patient Responsibilities

The HSCRC's proposed language in this section of its document is fair and reasonable, with the proposed addition at the end of the first bulleted proposal of the words "unless good cause exists". This should language should also be added to the second bulleted policy regarding a material change in the patient's financial situation.

Patient Education and Outreach

Patients should receive written information in 14 point print as inpatients and in the emergency room. The information should be in English, Spanish and also in another language if the hospital serves an area where more than 3% percent of the population speaks another language as their primary language.

In addition, hospitals should seriously consider, as a part of patient education and outreach, to give out information to consumers on what may occur if they do not pursue financial assistance options or do not pay their bills. This could be a voluntary measure but could make plain to the consumer how failure to pursue all options will lead to bad credit or collection that may not be necessary if the consumer simply is diligent in communicating with the hospital. There are several examples available through sources gathered by the Legal Aid Bureau, Inc., that could be used as a template for this outreach information.

II. Collection Policies

It would be beneficial to consumers to:

- Ensure that the hospital's Board of Directors is aware of the ongoing status of the institution's financial assistance and collection policies by reporting on the level of financial assistance (including the number of consumers receiving assistance and their household incomes and the average amount of assistance per consumer). The Board of Directors should also review and approve these policies annually or bi-annually, unless the policy changes.

  As to this topic there was a remarkable amount of discussion regarding the reporting to the Board of Directors on this subject. Representatives from hospitals stated that the Board would not want to hear this information. It is not clear if this meant that a Board of Directors would not want to hear the information simply because it was bad news or because the Board would have no interest. As collections have a significant effect on the business side of a hospital's operation,

it would seem that this information should be supplied to the Board of Directors in particular. Further, as the Maryland Legislature passed legislation specifically designed to remedy issues that arose with regard to financial assistance and debt collection, it would seem that a hospital's Board would want to be responsible and ensure that as an institution, the hospital was complying with the law. Finally, in its role as an important partner in the community, a hospital should want to have the public know that its Board of Directors is privy to all important information regarding all parts of a hospital's operation, including financial assistance and collection information.

- Not report a debt to a credit bureau unless the reporting was specifically authorized by an authorized senior officer of the hospital. Once the debt is paid the debt will be reported as paid and removed.

- To have the hospital provide a statement of the total cost of the hospital services and make clear that physician's services are not included.

- To have clear information about how to dispute a bill and how to contact a *live* person to discuss the bill and respond within 30 days and have the information available in the languages for which it has onsite interpreter services.

- To not assign patient accounts to a third party collector until 120 days from the date of the first bill sent and continue to work with consumers during and after the 120 day period to negotiate a payment plan. Consumers should also be able to make the payment directly to the hospital before and after the 120 day period. However, if the hospital is able to show that a consumer has acted in bad faith on more than two occasions in the past with respect to giving of false information such as regarding their billing address in an attempt to evade payment, the hospital can assign the bill for collection in a period of less than 120 days.

- To develop a system to accurately interface with medical assistance and insurance companies before a bill is sent for collection. In order to do this, hospitals must take steps to assure vigilance in making certain a person is not covered by medical assistance prior to collection action because there are still cases that escape notice and therefore there must be a uniform system put into place with effective backup that will ensure that someone does not fall through the cracks.

- That third party collectors shall:

i. Agree in writing to abide by the hospital's credit and collection policies.
ii. Provide the patients with information on how to file a grievance or complaint regarding the bill or the actions of the collector, give the patient the opportunity to file such a grievance or complaint, and forward the grievance or complaint to the hospital.
iii. Not file suit against a consumer without prior approval from a hospital authorized senior officer.

Other Collection Policies

It would be in the best interest for consumers and their immediate families if a hospital would not be able to taken action to collect on a judgment lien on a patient's primary residence while they lived in the property. Further, the action could not take place after their death if the primary residence was still inhabited by the consumer's spouse, domestic partner, aged parent or dependant children. A discussion arose on this issue and it did not appear that hospital representatives wanted to enforce a judgment lien while a consumer patient was still alive and in the home or their immediate family was living in the house. It appeared that hospital representatives were concerned with two issues: (1) transferring the property beyond the reach of the hospital so that it could not be recovered; (2) losing the hospital's priority to recover its judgment lien to another creditor. These issues are addressed in an attached memorandum on judgment liens that is attached to the HSCRC's final report.

Miscellaneous Policies

- It is in the best interest of consumers to have established procedures that can be followed to appeal the denial of financial assistance and establishment of payment plans. The notion of an appeal is fundamental to fairness and in this country's decision making process. A suggestion was made to establish standards and that is reasonable so long as those standards are a part of an established procedure. Any such procedure should have at least the following:

    1. Clear time lines for making an appeal and receiving a decision.

    2. Clear directions as to how a consumer can prepare and file an appeal. The directions should also make clear what the consumer can appeal, what the reviewer will take into account and what will be the factors considered in affirming or overturning the decision below, what new or additional information the consumer may want to include in the appeal.

3. Preprinted forms that are easy for the consumer to follow that allow for consumers to check off certain information and also allow the consumer to write information regarding the basis of the appeal.

- Prejudgment interest should not be charged to any self pay patients however, it also does not appear that any interest can be charged to anyone without an agreement between the parties by contract and then the appropriate rate should follow that permitted under the Maryland Constitution that provides for 6%.

I have appreciated being a part of this Workgroup and I hope that the recommendations in this letter will be useful in formulating final policies and future regulations.

Sincerely,

Louise M. Carwell
Senior Staff Attorney
For Consumer Law

MHA/HOSPITAL COMMENTS ON
HSCRC PATIENT FINANCIAL ASSISTANCE AND
DEBT COLLECTION WORK GROUP
DISCUSSION GUIDE

I. Financial Assistance Eligibility Thresholds

MHA Recommendation 1—At a minimum:

- Individuals with income below 150 percent of FPL are eligible for free care; and
- Individuals with income above 150 percent of FPL and below 200 percent of FPL are eligible for reduced cost care.

Rationale

- The legislature concluded this was the appropriate standard given today's environment in Maryland.

- Provides equitable access to financial assistance, regardless of a patient's community or where hospital services are accessed.

- Maintenance of effort provision contained in the recently promulgated regulations already protects against hospitals walking away from more generous policies.

- State health care coverage expansion is on hold.

- Extent of federal health care reform is uncertain at this juncture.

- Going above 200 percent of FPL would be higher than the median income in certain counties in Maryland and would result in a significant percentage of the service area of some hospitals being eligible for financial assistance.

- A uniform policy improves the transparency of hospital policies, making it easier for patients to understand their rights and responsibilities.

- Maryland hospitals' mark-up of charges over costs is much lower than other states.

II. Special Treatment of Certain Categories of Income and Assets

MHA Recommendation 1—All forms of income should be considered assets.

Rationale

- Treating certain types of income differently could lead to unintended inequities, e.g., a 60 year old with sufficient retirement funds to retire early and a 60 year old with no retirement income who continues to work.

- Other states have not applied special treatment for certain types of income.

- Simplicity.

- Other types of protections/exclusions may be more appropriate (see several of the recommendations below).

MHA Recommendation 2—Exclude a patient's primary residence from being considered an asset.

Rationale

- Prevents dislocation and significant financial burden for patients who have limited means, i.e., meet the income and liquid asset tests.

MHA Recommendation 3—Exclude $10,000 of liquid assets (assets that can be readily converted to cash). Assets above $10,000 would be used to pay the patient's hospital bill.

Rationale

- Protects those with limited income from having to liquidate $10,000 in assets and protects households from small economic shocks.

- Protects against those with substantial assets, but limited income, from avoiding reasonable responsibility.

III. Medical Hardship for Medically Indigent Patients

MHA Recommendation 1—Require all hospitals to develop a policy for medical hardship financial assistance.

Rationale

- Places responsibility on each hospital to balance available hospital resources against needs of its community and the hospital's mission.

- Most states have no uniform policy in this area.

- While 27 Maryland hospitals now have a medical hardship policy, all would be required to have one.

- Because there are so many variables that go into the equation, it is difficult to establish one uniform standard, e.g., size of bill relative to income, ability to pay, median income for the hospital's service area, ongoing medical expenses, family size, etc.

- Allowing hospital flexibility would protect against insurance carriers offering limited benefit plans or tailoring benefits in individual markets and/or insurance denial practices to reduce their own liability and taking advantage of the predicted benefits offered by hospitals.

IV. Collection Procedures

MHA Recommendation 1—Exclude those patients from collection action and court judgments who:

- Qualify for free care and have completed the uniform hospital financial assistance application;
- Have a completed medical assistance application pending;
- Are currently a medical assistance recipient *(please note: this may need further clarification)*; or
- Are making timely payments in accordance with an agreed upon payment plan.

Rationale

- Provides clear guidance for both hospitals and their collection agents.

MHA Recommendation 2—Specify that patients have personal responsibility related to the financial aspects of their health care needs, including:

- Cooperate at all times by providing complete and accurate insurance and financial information;
- Provide requested data to complete Medical Assistance applications in a timely manner;
- Authorize the hospital to verify the employment and credit information provided by the patient; and
- Notify the hospital of any changes in circumstances.

Rationale

- Helps to ensure payers are not unfairly burdened with bad debt.

MHA Recommendation 3—Do not require hospitals to document reasonable attempts to establish other means of payment prior to collection action and prior to seeking court judgment.

Rationale

- Hospitals already have a strong financial incentive to undertake these efforts.

MHA Recommendation 4—Do not establish a minimum window of time for patient and hospital efforts to reconcile payment, prior to collection action.

Rationale

- Hospitals utilize a variety of programs that can accurately and fairly identify individuals likely to not pay.

- Hospitals should not be required to expend unnecessary resources.

MHA Recommendation 5—Do not prohibit the reporting of non-discretionary medical debt to credit agencies.

Rationale

- Would take away hospital leverage to encourage patients that can pay to pay.

- Would do a disservice to all other potential creditors.

MHA Recommendation 6—Limit post-judgment interest to the current state limit of 10 percent.

Rationale

- HB 1069 prohibited hospitals from charging interest before a court judgment is obtained.

- Several jurisdictions automatically apply interest post judgment.

- Encourages patients to pay their hospital bill prior to judgment.

- Limits interest charged post-judgment to a reasonable amount.

MHA Recommendation 7—Allow liens to be placed on a patient's primary residence but prohibit execution (forced sale or foreclosure) of the lien until transfer of the property.

Rationale

- Protects against patient dislocation and significant and disruptive financial burden.

- Consistent with state Medical Assistance policy.

MHA Recommendation 8—Protect individuals from liens, garnishment, and attachments who:

- Qualify for free care and have completed the uniform hospital financial assistance application;
- Have a completed Medical Assistance application pending;
- Are currently a Medical Assistance recipient; or
- Are making timely payments in accordance with an agreed upon payment plan.

Rationale

- Provides clear guidance for both hospitals and their collection agents.

V. Patient Education and Outreach on Availability of Financial Assistance

MHA Recommendation 1—No changes to existing requirements for patient education and outreach.

Rationale

- Hospitals are currently required to post notices throughout the hospital.
- Hospitals are currently required to provide each patient with an information sheet on financial assistance before discharge, with the hospital bill, and on request.
- Hospitals currently devote extensive resources to assist patients in qualifying for Medical Assistance.
- Patient financial assistance information sheet currently must be provided in Spanish.
- Hospitals just recently made significant changes to meet the June 1 deadline of HB 1069.

MHA Recommendation 2—Implement "One-E-App" statewide.

Rationale

- Would facilitate qualifying eligible patients for current government programs.
- Would significantly reduce administrative costs.

VI. Special Treatment of Private Psychiatric and Chronic Care Hospitals

MHA Recommendation 1—In addition to the requirements for qualification for financial assistance at acute care hospitals, to qualify for financial assistance for care provided in a chronic hospital the patient's *medical condition* required a chronic hospital level of care on admission and throughout the stay.

Rationale

- Chronic hospital patients have significantly longer lengths of stay than acute care patients typically resulting in large bills.
- Chronic hospitals are currently experiencing discharge issues with patients the state has declassified as needing a chronic level of care.

MHA Recommendation 2—Limit the exclusion of liquid assets to $2,500.

Rationale

- Chronic hospital patients have significantly longer lengths of stay than acute care patients typically resulting in large bills.

MHA Recommendation 3—No separate rules for private psychiatric hospitals *unless* the state reduces or eliminates state psychiatric hospital capacity or the Purchase of Care program.

Rationale

- Private psychiatric hospitals do not have the same amount of uncompensated care built into their rates.

- If the state changes the role it plays in providing inpatient psychiatric care to the uninsured, the amount of uncompensated care required to be provided by private psychiatric hospitals would increase significantly.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§ 19-207, 19-212, and 19-215, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on October 14, 2009, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about February 9, 2010.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August, 1987), which has been incorporated by reference.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410)

764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until December 7, 2009. A hearing may be held at the discretion of the Commission.

.02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The "Accounting and Reporting System for Hospitals", also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a)–(q) (text unchanged)

(r) Supplement 18 (April 06, 2009)[.]**;** and

(s) Supplement 19 (February 9, 2010).

(3)-(5) (text unchanged)

B.-D. (text unchanged)

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-214, 19-214.1, 19-214.2, and 19-214.3 Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .26B** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on October 14, 2009, notice of which was given pursuant to State Government Article, §10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about February 9, 2010.

Statement of Purpose

The purpose of this action is to raise the current income threshold for receiving free or reduced medically necessary hospital care unless such increase would yield undue financial hardship to a hospital.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See Attachment A.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410)

764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until December 7, 2009. A hearing may be held at the discretion of the Commission.

.26 Differentials

A. – A-1. (text unchanged)

B. Working Capital Differentials – Payment of Charges.

(1) – (4) (text unchanged)

(5) Hospital Financial Assistance Responsibilities.

(a) (text unchanged)

(i) Free medically necessary care to patients with family income at or below [150] 200 percent of the federal poverty level; and

(ii) Reduced-cost, medically necessary care to low-income patients with family income between [150] 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital.

(b) A hospital whose current financial assistance policy, that is, as of May 8, 2009, provides for free or reduced-cost medical care to patients at an income threshold[s] higher than those [the 150 percent level] set forth above may not reduce that income threshold.

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

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of charity care provided; and

(v) Other relevant factors.

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

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

[(c)] (f) (text unchanged)

[(d)] (g) (text unchanged)

C. (text unchanged)

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

TO: **Commissioners**

FROM: **Legal Department**

DATE: **October 9, 2009**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

November 4, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
December 9, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**

Please note, Commissioner packets will be available in Commission offices at 8:00 a.m.

The agenda for the Executive and Public Sessions will be available for your review on the Commission's Web Site, on the Monday before the Commission Meeting. To review the agenda, visit the Commission's web site at http://www.hscrc.state.md.us