

Article - Health - General

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§19–214.1.

(a) (1) In this section the following words have the meanings indicated.

(2) “Financial hardship” means medical debt, incurred by a family over a 12-month period, that exceeds 25% of family income.

(3) “Medical debt” means out-of-pocket expenses, including co-payments, coinsurance, and deductibles, for medical costs.

(4) “Medically necessary care” means care that is:

(i) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(ii) Consistent with accepted standards of good medical practice; and

(iii) Not primarily for the convenience of the patient, the patient’s family, or the provider.

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

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

(i) Free medically necessary care to patients with family income at or below 200% of the federal poverty level, calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided;

(ii) Reduced-cost medically necessary care to low-income patients with family income above 200% of the federal poverty level, calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided;

(iii) A description of the availability of the payment plan required under § 19–214.2(d) of this subtitle; and

(iv) A mechanism for a patient to request the hospital to reconsider the denial of free or reduced–cost care that includes in the request:

1. The Health Education and Advocacy Unit is available to assist the patient or the patient’s authorized representative in filing and mediating a reconsideration request; and

2. The address, phone number, facsimile number, e–mail address, mailing address, and website of the Health Education and Advocacy Unit.

(3) (i) The Commission by regulation may establish income thresholds higher than those under paragraphs (2) and (4) 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.

(4) Subject to income thresholds set under paragraph (3) of this subsection, the financial assistance policy required under this subsection shall provide reduced–cost medically necessary care to patients with family income below 500% of the federal poverty level who have a financial hardship.

(5) (i) If a patient is eligible for reduced–cost medically necessary care under paragraph (2)(ii) of this subsection, the hospital shall, at a minimum, reduce the patient’s out–of–pocket expenses for the regulated hospital service:

1. For a patient with family income of at least 201% but not more than 250% of the federal poverty level, by 75%; and

2. For a patient with family income of more than 250% but not more than 300% of the federal poverty level, by 60%.

(ii) If a patient is eligible for reduced-cost medically necessary care under paragraph (4) of this subsection, the hospital shall, at a minimum, reduce the patient's out-of-pocket expenses for the regulated hospital service:

1. For a patient with family income of at least 201% but not more than 250% of the federal poverty level, by 75%;

2. For a patient with family income of more than 250% but not more than 300% of the federal poverty level, by 60%;

3. For a patient with family income of more than 300% but not more than 350% of the federal poverty level, by 50%;

4. For a patient with family income of more than 350% but not more than 400% of the federal poverty level, by 45%;

5. For a patient with family income of more than 400% but not more than 450% of the federal poverty level, by 40%; and

6. For a patient with family income of more than 450% but not more than 500% of the federal poverty level, by 35%.

(6) If a patient has received reduced-cost medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost medically necessary care.

(7) The financial assistance policy required under this subsection shall provide presumptive eligibility for free medically necessary care to a patient who is not eligible for the Maryland Medical Assistance Program or Maryland Children's Health Program and:

(i) Lives in a household with a child who is enrolled in the free and reduced–cost meal program and is eligible for the program based on the household’s income;

(ii) Receives benefits through the federal Supplemental Nutrition Assistance Program;

(iii) Receives benefits through the State’s Energy Assistance Program;

(iv) Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children; or

(v) Receives benefits from any other social service program as determined by the Department and the Commission.

(8) (i) A hospital may consider only household monetary assets in excess of \$100,000 when determining eligibility for free and reduced–cost care under the hospital’s financial assistance policy.

(ii) If a hospital considers household monetary assets under subparagraph (i) of this paragraph, retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred–compensation plans qualified under the Internal Revenue Code or nonqualified deferred–compensation plans shall be excluded.

(9) (i) In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

1. A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

2. Biological children, adopted children, or stepchildren; and

3. Anyone for whom the patient claims a personal exemption in a federal or State tax return.

(ii) For a patient who is a child, the household size shall consist of the child and the following individuals:

1. Biological parents, adopted parents, or stepparents or guardians;

and

2. Biological siblings, adopted siblings, or stepsiblings;

3. Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

(10) (i) A hospital shall provide notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill.

(ii) The notice required under subparagraph (i) of this paragraph shall state that the patient has up to 240 days after the day the patient receives the initial hospital bill to apply for financial assistance from the hospital.

(iii) 1. The hospital shall obtain documentation ensuring that the patient or the patient's authorized representative acknowledges the patient's receipt of the notice before discharging the patient.

2. If a patient chooses not to apply for financial assistance, the patient's documented acknowledgment shall indicate that the patient is not applying on the day of the acknowledgment but may apply within 240 days immediately following the patient's receipt of the initial hospital bill.

(11) The hospital shall consider any change in the patient's financial circumstance that occurs during the 240-day period following the patient's receipt of the initial hospital bill if the patient informs the hospital of the change in financial circumstance on or before the conclusion of the 240-day period.

(c) (1) A hospital shall post a notice in conspicuous places throughout the hospital, including the billing office, informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(2) The notice required under paragraph (1) of this subsection shall:

(i) Be in simplified language in at least 10 point type; and

(ii) Be provided in the patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5% of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(d) 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.
- (e) 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.
- (f) (1) Each hospital shall develop an information sheet that:
- (i) Describes the hospital’s financial assistance policy and includes a section that allows for a patient to initial that the patient has been made aware of the financial assistance policy;
 - (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;
 - (v) Includes a statement that physician charges are not included in the hospital bill and are billed separately; and

(vi) Informs patients of the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.

(2) The information sheet shall:

(i) Be in simplified language in at least 10 point type; and

(ii) Be in the patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5% of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(3) 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;

(iii) On request; and

(iv) In each written communication to the patient regarding collection of the hospital bill.

(4) The hospital bill shall include a reference to the information sheet.

(5) 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.

(g) 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, including the patient's rights and obligations with regard to reduced-cost medically necessary care due to a financial hardship;

(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.

(h) Each hospital shall develop a procedure to determine a patient's eligibility under the hospital's financial assistance policy in which the hospital:

(1) Determines whether the patient has health insurance;

(2) Determines whether the patient is presumptively eligible for free or reduced-cost care under subsection (b)(7) of this section;

(3) Determines whether uninsured patients are eligible for public or private health insurance;

(4) To the extent practicable, offers assistance to uninsured patients if the patient chooses to apply for public or private health insurance;

(5) To the extent practicable, determines whether the patient is eligible for other public programs that may assist with health care costs;

(6) Uses information in the possession of the hospital, if available, to determine whether the patient is qualified for free or reduced-cost care under the hospital's financial assistance policy; and

(7) When a patient submits a completed application for financial assistance, determines the patient's eligibility under the hospital's financial assistance policy within 14 days after the patient applies for financial assistance and suspends any billing or collections actions while eligibility is being determined.

(i) A hospital may not:

(1) Use a patient's citizenship or immigration status as an eligibility requirement for financial assistance; or

(2) Withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

(j) Each hospital shall submit to the Commission annually at times prescribed by the Commission:

(1) The hospital's financial assistance policy developed under this section; and

(2) An annual report on the hospital's financial assistance policy that includes:

(i) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

(ii) The total number of inpatients and outpatients who received:

1. Free care during the immediately preceding year; and

2. Reduced-cost care for the prior year;

(iii) The total number of patients who received financial assistance during the immediately preceding year by race or ethnicity and gender;

(iv) The total number of patients who were denied financial assistance during the immediately preceding year by race or ethnicity and gender;

(v) The total amount of the costs of hospital services provided to patients who received free care; and

(vi) The total amount of the costs of hospital services provided to patients who received reduced-cost care that was either covered by the hospital as financial assistance or that the hospital charged to the patient.

(k) (1) The Commission shall post on its website each hospital's financial assistance policy and annual report.

(2) The Commission shall compile the reports required under subsection (j) of this section and issue a hospital financial assistance report.

(3) The hospital financial assistance report required under paragraph (2) of this subsection shall be made available to the public free of charge.

(4) On or before December 1 each year, the Commission shall submit a copy of the annual hospital financial assistance report issued under paragraph (2) of this subsection, in accordance with § 2-1257 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee.

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