Maryland
Hospital Association

Senate Bill 404 - Hospitals - Financial Assistance - Medical Bill Reimbursement Process

Position: *Support*
February 23, 2023
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 404. Maryland hospitals have only one core mission: to provide the best patient care possible. Hospitals believe every person should receive the care they need without financial worry or hardship. Maryland hospitals make every effort to inform patients about available financial assistance, including free or reduced-cost care. That includes helping patients enroll in Medicaid or other insurance options and to set up reasonable payment options when needed. Over the past three legislative sessions the General Assembly acted to strengthen Maryland's already robust requirements around financial assistance and billing.

The reimbursement process prescribed in SB 404 results from recommendations in the Health Services Cost Review Commission's (HSCRC) "Free Hospital Care Refund Process" report, which stems from House Bill 694 of the 2022 legislative session. HSCRC convened stakeholders including the Comptroller's Office, Department of Human Services (DHS), and MHA, to develop a process to identify and reimburse patients who may have been billed and paid out-of-pocket for hospital services while unknowingly eligible for free care.

MHA was actively involved in the work group over the interim. Early deliberations confirmed significant gaps in information across parties. Various state agencies have a component of data needed to determine eligibility for free or reduced-cost care, but no state agency has complete information, and hospitals must rely on patients to share data. If a patient does not provide this information, the hospital is likely unable to determine eligibility.

Maryland hospitals acknowledge that if a patient was billed for services when they were eligible for free care it was done unknowingly. This bill will facilitate data sharing necessary to identify these patients. If a patient paid a bill they should not have received, they will be refunded.

While HSCRC did not recommend a specific process to share data, MHA agrees with the provisions in SB 404. While "Option 3" (see attached) places an extensive data collection and data sharing burden on hospitals in the midst of severe workforce shortages, we are supportive because we are a partner in this work.

SB 404 would require hospitals to identify all patients who paid out of pocket for services rendered between 2017 and 2021and share this data and safe addresses with the Office of the Comptroller. The Office of the Comptroller would then match this data with available tax information to identify patients with income at or below 200% of the federal poverty level. This

data would be used to send letters to patients to inform them that they are eligible for reimbursement. The Comptroller's Office would also share this information with DHS and the Department of Education to match with patients enrolled in the Energy Assistance, Supplemental Nutrition Assistance Program, and/or free and reduced cost meal programs. These individuals would be considered eligible for free care. Patients could then share these letters with the hospitals where they received services to obtain reimbursement if out-of-pocket payments were made.

Protecting the privacy of patients and their data is of the utmost importance for our hospitals. Even with safeguards in place, exchanging data among state agencies and hospitals increases the risk of a breach. We appreciate the bill acknowledges sharing data must be done in accordance with state and federal laws. The hospital field will work closely with HSCRC and state partners over the interim to implement this process accordingly.

Further, we hope the appropriate state agencies and stakeholders will continue to collaborate on opportunities to reduce consumer cost exposure and ease barriers to accessing care that result from aggressive payer practices and underinsurance.

For the aforementioned reasons, we respectfully request a ***favorable*** report on SB 404.

For more information, please contact:
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OVERVIEW OF MARYLAND'S HOSPITAL FINANCIAL ASSISTANCE PROGRAMS

If the patient or their representative has questions regarding financial assistance and/or billing concerns, please contact the hospital where they received the services.[1]

TYPES OF HOSPITAL FINANCIAL ASSISTANCE AVAILABLE TO PATIENTS

- Free care:
  - Patients with family income at or below 200% of the federal poverty level (FPL) are eligible for free, medically necessary care
  - Additionally, unless a patient is otherwise eligible for Medicaid[2] or CHIP, beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free care. This is referred to as "presumptive eligibility for free care." Hospitals will attempt to determine whether the patient is presumptively eligible for free care using existing information:
    - Households with children in the free or reduced lunch program
    - Supplemental Nutrition 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 and Children (WIC)
    - Other means-tested social services programs deemed eligible for hospital free care policies by the Maryland Department of Health and the Health Services Cost Review Commission
- Reduced-cost care:
  - Low-income patients with family income between 200% and 300% of the FPL are eligible for reduced-cost, medically necessary care
  - Patients with family income below 500% of the FPL who have a financial hardship[3] are eligible for reduced-cost, medically necessary care

If the patient is not sure whether they qualify for financial assistance, the patient should contact the hospital where they received services.

FINANCIAL ASSISTANCE APPLICATION

Patients who were not determined presumptively eligible for free care by the hospital can apply for financial assistance. Information on how to apply for financial assistance is included with the bill. All Maryland hospitals use the same financial assistance application form.[4] ***Patients can apply up to 240 days (about eight months) after the date the first post-discharge billing statement is provided***. Hospitals will take into consideration any change in the patient's financial circumstances that occurs within this time frame. Patients should contact the hospital directly if they need more time to apply, if they are unsure whether someone who has contacted them is associated with the hospital, or if they

[1] List of links to Maryland hospital financial assistance policies: mhaonline.org/transforming-health-care/caring4md/financial-assistance
[2] Medicaid in Maryland has no patient cost-sharing.
[3] "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income. "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.
[4] Uniform Financial Assistance Form (Word download): hscrc.maryland.gov/Documents/public-interest/MDuniformFinancialAssistanceApp.doc

need help completing the application. Patients are strongly encouraged to promptly respond to hospital follow-up inquiries regarding their application to facilitate processing**.** A telephone number for the hospital's billing department is normally included with the bill.

PROCEDURAL REQUIREMENTS

Hospitals' procedures to determine a patient's eligibility for financial assistance include, among other things:

- Determine whether the patient has health insurance
- Determine whether the patient is presumptively eligible for free or reduced-cost care
- Determine whether uninsured patients are eligible for public or private health insurance
- To the extent practicable, offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance
- To the extent practicable, determine whether the patient is eligible for other public programs that may assist with health care costs
- Use information in the possession of the hospital, if available, to determine whether the patient is qualified for free or reduced-cost care

CITIZENSHIP OR IMMIGRATION STATUS

A hospital may not use a patient's citizenship or immigration status as an eligibility requirement for financial assistance.

PAYMENT PLANS

Payment plans are available to patients irrespective of their insurance status with family income between 200% and 500% of the FPL who request assistance. However, any patient who may need a payment plan—regardless of family income—should contact the hospital where they received services to discuss available payment options.

NOTICE OF FINANCIAL ASSISTANCE POLICIES

Hospitals provide patients with notice of their financial assistance policies in two main ways.

- Information sheets: This describes the hospital financial assistance policies and is provided to the patient, the patient's family, or the patient's authorized representative at the following times:
  - Before the patient receives scheduled medical services
  - Before discharge
  - With the hospital bill
  - On request
  - In each written communication to the patient regarding collection of the hospital bill
- Information sheets include 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 understand how to apply for free and reduced-cost care
  - Includes space for patients to initial they have been made aware of the financial assistance policy
- Notice in conspicuous places: Hospitals post notices 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

Table 1: Comparison of Process Options

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

<table>
<tr><th>Other Policy Issues</th><th>Option 1: Hospital Data Only</th><th>Option 2: Start with Comptroller Data</th><th>Option 3: Start with Hospital Data</th><th>Option 4: Start with HSCRC Data</th></tr>
<tr><td>Protecting Domestic Violence Survivors and other Special Populations</td><td colspan="4">All options meet the safe address requirement. Additional concerns related to alternative outreach methods (including patient portals) and the content of any messages to patients is discussed elsewhere in this report and applies to all the process options.</td></tr>
<tr><td>Minimizing the burden on patients who may be eligible for refunds</td><td>Highest: This process requires the most work by patients</td><td colspan="3">Lower: State agency and hospital data is used to identify patients who are likely due a refund, such that patients will not need to provide evidence of income or social services program enrollment.</td></tr>
<tr><td rowspan="2">Minimizing the burden and cost to hospitals</td><td rowspan="2">High: This option results in the largest burden for hospitals as hospitals must evaluate information from patients to determine income and/or social services program enrollment. Costs would depend on the method of communication. A public service announcement (PSA) campaign or electronic notices (e.g., email or portal) could lower costs, whereas mailed letters would have higher costs.</td><td>Lower: Options 2, 3, and 4 reduce hospital burden by using State data to determine income or social services program enrollment.</td><td>Lowest: Options 2, 3, and 4 reduce hospital burden by using State data to determine income or social services program enrollment.</td><td>Lower: Options 2, 3, and 4 reduce hospital burden by using State data to determine income or social services program enrollment.</td></tr>
<tr><td colspan="3">Under Options 2-4, hospitals will need to contact patients, which takes resources. The resources needed to contact patients under Options 2-4 are less than the resources under Option 1 due to the smaller list of patients being contacted</td></tr>
<tr><td>Minimizing the burden to State agencies</td><td>Lowest: No State agency data is used in this option.</td><td>Higher: This option requires extensive data sharing between State agencies.</td><td>Highest: This option requires data sharing between State agencies.</td><td>Higher: This option requires extensive data sharing between State agencies.</td></tr>
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