Draft Payment Policy Guidelines, as required by HB 565, for January Workgroup Meeting and Comment

Version Date: 12/18/21

Health-General § 19-214(e)(3), as amended by HB 565 (2021) and HB 565 § 2, requires the Health Services Cost Review Commission to develop guidelines for hospital income-based payment plans. These draft guidelines are for review and discussion during workgroup meetings in January and February. Revised draft guidelines may be provided before the February meeting.

Written comments on these guidelines are welcomed by HSCRC staff. HSCRC staff will provide due dates for such comments at a later date. In addition to the opportunity to provide written and verbal comments during the workgroup process, stakeholders will have an opportunity to provide written comments when the draft guidelines are presented to the HSCRC in a public meeting after the workgroup process.

Once finalized, these guidelines will be incorporated by reference into COMAR 10.37.10.26. COMAR 10.37.10.26 will also be updated to reflect requirements of HB 565 that are not included in these guidelines.

Draft Guidelines	**Notes, including statutory language from HB 565** ***These notes will not be included in the final guidelines***
1) **Scope:** These guidelines apply to payment plans offered by hospitals to all patients to pay for hospital services after the services are provided. These guidelines do not apply to pre-payment plans.	The purpose of this language is to exclude prepayment plans from the scope of these guidelines.
2) **Access to payment plans:** Hospitals must make payment plans available to all patients, irrespective of their: a) Insurance status; b) Citizenship status; or c) Immigration status d) Eligibility for reduced cost care, including reduced cost care due to financial hardship.	HG 19-214.2(e)(3)(i) (HB 565): THE COMMISSION SHALL DEVELOP GUIDELINES, WITH INPUT FROM STAKEHOLDERS, FOR AN INCOME–BASED PAYMENT PLAN OFFERED UNDER THIS SUBSECTION…
3) **Notice:** a) *Notice of availability of payment plans:* In the information sheet required under COMAR 10.37.10.26 A, hospitals must:	The payment plan is not currently in the information sheet. As required in COMAR 10.37.10.26, the information sheet is given (a) Before the patient receives scheduled medical services; (b) Before discharge; (c) With the hospital bill; (d) On request; and (e) In each

i) Inform all patients of the availability of a payment plan; and ii) Provide 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 how to apply for a payment plan.	written communication to the patient regarding collection of the hospital bill. This timing matches the requirements in HB 565 for provision of information on payment plans. HG 19-214.2(e)(2) (HB 565): A HOSPITAL SHALL PROVIDE THE INFORMATION UNDER PARAGRAPH (1) OF THIS SUBSECTION TO THE PATIENT, THE PATIENT'S FAMILY, THE PATIENT'S AUTHORIZED REPRESENTATIVE, OR THE PATIENT'S LEGAL GUARDIAN: (I) BEFORE THE PATIENT IS DISCHARGED; (II) WITH THE HOSPITAL BILL; (III) ON REQUEST; AND (IV) IN EACH WRITTEN COMMUNICATION TO THE PATIENT REGARDING COLLECTION OF HOSPITAL DEBT.
b) *Notice of payment plan terms:* Hospitals shall provide a written copy of the payment plan to the patient before the due date of the patient's first payment. The payment plan must state: i) The amount of medical debt owed to the hospital; ii) The amount of each periodic payment expected from the patient under the payment plan; iii) The number of periodic payments expected from the patient under the payment plan. iv) The expected due dates for each payment from the patient; and v) The expected date by which the account will be paid off in full.	HG 19-214.2(e)(3)(i)(I) (HB 565): 1. THE AMOUNT OF MEDICAL DEBT OWED TO THE HOSPITAL; 2. THE DURATION OF THE PAYMENT PLAN BASED ON A PATIENT'S ANNUAL GROSS INCOME; For discussion: interaction with new federal regulations from the Consumer Financial Protection Bureau which apply to debt collectors. The Maryland Office of the Commissioner of Financial Regulation is developing a FAQ for debt collectors on HB 565, which will be released separately from these guidelines.

4) **Payment Amount** a) Under a payment plan subject to these guidelines, a hospital shall not require a patient to make total payments in a month that exceed 5% of the lessor of the individual patient's family federal or State adjusted gross monthly income for all medical debt with the hospital incurred by a family. ***Discussion item:*** What language would you suggest related to a hospital consolidating multiple debts from a patient into a single payment plan. Do the modification provisions apply (e.g. mutual agreement)? What about other requirements?	HG 19-214.2(e)(3)(i)(4)(B) (HB 565): MAY NOT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; AND Adjusted income is income minus adjustments. Adjustments to Income include such items as Educator expenses, Student loan interest, Alimony payments or contributions to a retirement account. Medical expenses are a deduction (not an adjustment) and are not a factor in determining federal adjusted gross income. Discussion item: Determining "adjusted" **individual** income is likely not reasonable for joint/family filers. Adjusted income on joint tax returns is not disaggregated by individual- adjustments apply to the tax filing unit. HSCRC plans to interpret " THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME" to mean "THE INDIVIDUAL PATIENT'S FEDERAL OR STATE [family] ADJUSTED GROSS MONTHLY INCOME" to avoid needing to determine individual adjusted gross income. Family income is used in the financial assistance determination. Discussion item: Unintended consequences of requiring income validation.
b) In determining the payment amounts for patients, hospitals must treat patients with family incomes below 500% of FPL with financial hardship (i.e. out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs from the previous 12-month period that exceed 25 percent of family income) in the same manner that hospitals treat individuals with family incomes between 200% and 300% FPL.	HG 19-214.2(e)(3)(i)(4)(B) (HB 565): GUIDELINES FOR THE PAYMENT AMOUNT THAT….SHALL CONSIDER FINANCIAL HARDSHIP, AS DEFINED IN § 19–214.1(A) OF THIS SUBTITLE;

c) ***Discussion item: Is this provision necessary/useful?***-- **Adjustments in payment amount:** A hospital may, in the terms of an original payment plan that exceeds 3 years in length, provide for periodic adjustments to the amount of the monthly payments based on changes in the individual patient's family federal or state adjusted gross monthly income. An adjustment to the payment amount may not require a patient to make payments in a month that exceed the percent of the individual patient's family federal or State adjusted gross monthly income that the patient paid under the initial terms of the payment plan. The hospital may not change the interest rate applicable to the payment plan when making such a modification. Subject to item 6 below, the length of the payment plan may change based on the change in the amount of the monthly payment. A hospital may not change the terms of the payment plan more often than every 3 years and the periodicity for such changes must be included in the original payment plan terms. The patient's consent to the original payment plan terms will be considered to be consent to subsequent adjustments to the payment amounts allowed under this provision. The hospital must provide the patient with an updated notice of all payment plan terms upon making a change to the payment amount under this provision.	
5) **Determining Income and Financial Hardship** a) Hospitals shall accept generally acceptable forms of documentation that verify income, such as pay stubs, and W2s. b) For purposes of determining financial hardship, hospitals shall accept generally acceptable forms of documentation that provide evidence of medical expenses, such as bills and/or explanation of benefits documents.	HG 19-214.2(e)(3)(i)(3) (HB 565): GUIDELINES FOR REQUIRING APPROPRIATE DOCUMENTATION OF INCOME LEVEL;

c) ***Discussion item-*** May the patient tell the hospital their income without providing any documentation? What documentation must a hospital have if the hospital relies on a patient's statement of their income (e.g. patient written/electronic signature)?	
6) **Duration of payment plan:** The duration of a payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5% of the lessor of the individual patient's family federal or State adjusted gross monthly income. If a payment plan is modified under these guidelines, the duration of the payment plan shall be recalculated based on this standard.	HG 19-214.2(e)(3)(i)(2) (HB 565): THE DURATION OF THE PAYMENT PLAN BASED ON A PATIENT'S ANNUAL GROSS INCOME;
7) **Interest** a) A payment plan provided to a patient by a hospital shall not charge and collect interest on the medical debt amount owed for patients who qualify for free or reduced-cost care under a payment plan. b) The hospital must be reasonable in determining whether to charge interest and the rate of interest to charge to individuals who do not qualify for free or reduced cost care. c) Interest may not begin before 180 days after the due date of the first payment. d) The hospital may not charge interest on bills incurred by self-pay patients in a payment plan. **Discussion item:** Including a maximum allowable interest rate. *Here are two possible options. HSCRC welcomes feedback on these options and welcomes alternative suggestions.* Maximum allowable Interest rate: **a.** Option 1: Finance charges under a payment plan, including interest, may not exceed 5% annually.	HG 19-214.2(e)(3)(i)(5)(HB 565). GUIDELINES FOR: A. THE DETERMINATION OF POSSIBLE INTEREST PAYMENTS FOR PATIENTS WHO DO NOT QUALIFY FOR FREE OR REDUCED–COST CARE, WHICH MAY NOT BEGIN BEFORE 180 DAYS AFTER THE DUE DATE OF THE FIRST PAYMENT; AND B. A PROHIBITION ON INTEREST PAYMENTS FOR PATIENTS WHO QUALIFY FOR FREE OR REDUCED–COST CARE HG 19-214.2(B)(3) THE POLICY SHALL…PROHIBIT THE CHARGING OF INTEREST ON BILLS INCURRED BY SELF–PAY PATIENTS BEFORE A COURT JUDGMENT IS OBTAINED; This has a direct impact on the length of the payment plan because of the limit on the amount that can be collected in a month. The annual all-payer update factor for hospital rates is set by HSCRC and is normally 3-4%/year. Growth in the update factor is constrained by Maryland's agreements with the federal

b. Option 2: Finance charges under a payment plan, including interest, may not exceed the annual hospital all-payer update factor for the year in which the payment plan is entered.	government to achieve Medicare savings under the Total Cost of Care agreement. The language "for the year in which the payment plan is entered." was added to ensure that the consumer isn't subject to annual changes in the interest rate based on the annual changes to the update factor.
8) **Prepayment:** A hospital shall not assess fees or otherwise penalize prepayment or early payment of a payment plan provided by a patient.	HG 19-214.2(e)(3)(i)(7) (HB 565): A PROHIBITION ON PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.
9) **Modification of Repayment Plans:** a) *Limitation on payment amount:* A hospital shall not modify a repayment plan in a way that requires a patient to make payments in a month that exceed the percent of the individual patient's family federal or State adjusted gross monthly income that the patient paid in the original payment plan.	HG 19-214.2(e)(3)(i)(6) (HB 565): GUIDELINES FOR MODIFICATION OF A PAYMENT PLAN THAT DOES NOT CREATE A GREATER FINANCIAL BURDEN ON THE PATIENT; AND This allows for an upward adjustment with increases in income, but doesn't allow for a change in the % of income charged. E.g. if the original plan was at 4% of monthly income, the new plan must also be at 4% of monthly income.
b) If a patient requests a modification to the terms of the payment plan, the hospital must respond in a timely manner and may not not refer the outstanding balance owed to a collection agency or for legal action until **XX** days after providing a response to the patient's request for a modification of the payment plan.	
c) *Mutual Agreement:* A hospital shall not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.	HG 19-214.2(b)(10)(ii) ALLOW THE PATIENT AND THE HOSPITAL TO MUTUALLY AGREE TO MODIFY THE TERMS OF A PAYMENT PLAN OFFERED UNDER SUBSECTION (E) OF THIS SECTION OR ENTERED INTO WITH THE PATIENT; AND
10) Termination of a payment plan:	HG 19-214.2(e)(4) (4) (I) A PATIENT SHALL BE DEEMED TO BE COMPLIANT

a) In the terms of the original payment plan, the hospital shall specify the terms under which the hospital may terminate the payment plan. b) The hospital may not terminate a payment plan for a single missed monthly payment in a 12-month period. c) If a hospital waives any additional missed payments that occur in a 12-month period and allows the patient to continue to participate in the income-based payment plan, the hospital- i) may not refer the outstanding balance owed to a collection agency or for legal action; ii) the hospital may add the amount of the missed payments as additional required payments, in the same amount as the missed monthly payments, at the end of the payment plan, extending the length of the payment plan; and iii) provide notice to the patient of the treatment of the missed payments, including any extension of the length of the payment plan. d) A hospital must include its policy relating to additional missed payments in a 12-month period in the original payment plan terms. *Discussion:* 1. If the payment plan is at the payment amount limit of 5% of monthly income, if the consumer makes up the missed payment in a year, can the monthly payments in the months that the consumer is making up the payment exceed 5% of monthly income? 2. At what point can the hospital write-off unpaid payments to bad debt, if ever? HSCRC expects hospitals to engage in "reasonable collection efforts" to protect the sustainability of the uncompensated care fund (which supports free and reduced cost care, as well as bad-debt).	WITH A PAYMENT PLAN IF THE PATIENT MAKES AT LEAST 11 SCHEDULED MONTHLY PAYMENTS WITHIN A 12–MONTH PERIOD. (II) IF A PATIENT MISSES A SCHEDULED MONTHLY PAYMENT, THE PATIENT SHALL CONTACT THE HEALTH CARE FACILITY AND IDENTIFY A PLAN TO MAKE UP THE MISSED PAYMENT WITHIN 1 YEAR AFTER THE DATE OF THE MISSED PAYMENT. (III) THE HEALTH CARE FACILITY MAY, BUT MAY NOT BE REQUIRED TO, WAIVE ANY ADDITIONAL MISSED PAYMENTS THAT OCCUR WITHIN A 12–MONTH PERIOD AND ALLOW THE PATIENT TO CONTINUE TO PARTICIPATE IN THE INCOME–BASED PAYMENT PLAN AND NOT REFER THE OUTSTANDING BALANCE OWED TO A COLLECTION AGENCY OR FOR LEGAL ACTION.

11) **Treatment of Loans and extension of credit:** *Discussion item:* Should all post-service financing made available by the hospital (or a partner) be subject to this payment plan guidance, including both traditional "payment plans" and loans?	
12) **Debt Collectors:** A debt collector shall be entitled to service payment plans entered into by its hospital clients, per the terms and conditions established by the hospital. Hospitals shall require that debt collectors operating under contract with the hospital abide by the requirements of these guidelines.	**Discussion item:** Hospitals use different types of vendors for bill collection and financial assistance (and insurance) eligible. HG 19-214.2(B)(1) PROVIDE FOR ACTIVE OVERSIGHT BY THE HOSPITAL OF ANY CONTRACT FOR COLLECTION OF DEBTS ON BEHALF OF THE HOSPITAL HG 19-214.2(K) IF A HOSPITAL DELEGATES COLLECTION ACTIVITY TO A DEBT COLLECTOR, THE HOSPITAL SHALL: (1) SPECIFY THE COLLECTION ACTIVITY TO BE PERFORMED BY THE DEBT COLLECTOR THROUGH AN EXPLICIT AUTHORIZATION OR CONTRACT; (2) REQUIRE THE DEBT COLLECTOR TO ABIDE BY THE HOSPITAL'S CREDIT AND COLLECTION POLICY; (3) SPECIFY PROCEDURES THE DEBT COLLECTOR MUST FOLLOW IF A PATIENT APPEARS TO QUALIFY FOR FINANCIAL ASSISTANCE; AND (4) REQUIRE THE DEBT COLLECTOR TO: (I) IN ACCORDANCE WITH THE HOSPITAL'S POLICY, PROVIDE A MECHANISM FOR A PATIENT TO FILE WITH THE HOSPITAL A COMPLAINT AGAINST THE HOSPITAL OR THE DEBT COLLECTOR REGARDING THE HANDLING OF THE PATIENT'S BILL; (II) FORWARD THE COMPLAINT TO THE HOSPITAL IF A PATIENT FILES A COMPLAINT WITH THE DEBT COLLECTOR; AND (III) ALONG WITH THE HOSPITAL, BE JOINTLY AND SEVERALLY RESPONSIBLE FOR MEETING THE REQUIREMENTS OF THIS SECTION.

	Note that these guidelines focus on payment plans (HG 214.2(e)(3)), not other provisions of HB 565. Staff felt a reference to debt collectors in these guidelines was important enough to include here, but did not incorporate all provisions of HB 565 into these guidelines. Other changes in law in HB 565 will be address separate in updates to regulations in COMAR 10.37.10.26.
13) **Application of Credit Provisions of Maryland Commercial Code:** An income-based payment plan is an extension of credit subject to Maryland credit regulations under the Annotated Code of Maryland, Commercial Law Article, Title 12. Accordingly, hospitals must elect or otherwise enter into an income-based payment plan under one of the subtitles thereunder. Pursuant to CL § 11-302(b)(6), if a hospital is making an extension of credit through a payment plan for services rendered under Subtitles 1, 9, or 10 of the Commercial Law Article, and is otherwise not making loans or acting as a loan broker, then an Installment License issued by the Commissioner of Financial Regulation is not required to engage in such activity. Reference the [FAQ from DOL] for additional information about this issue.	The Maryland Office of the Commissioner of Financial Regulation is working on a "Frequently Asked Question" document related to the application of these provisions to payment plans.
14) Books and Records. Discussion item: *Do we need book and records provisions for the hospitals? HSCRC plans to address HB 565 in the special audit procedures for hospitals, but has not yet made those changes.*	
15) **Reasonable Attempts to Collect Required:** Nothing in these guidelines shall be interpreted to obviate the requirements related to charges written off to bad debt as outlined in the HSCRC's Accounting and Budget Manual Section 100, including that hospitals may not write charges off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort.	

Appendix- For Reference Only

FPL thresholds 2021

Household size	100% FPL	200% FPL (x2)	300% FPL (x3)	400% FPL (x4)	500% FPL (x5)
1	$12,880	$25,760	$38,640	$51,520	$64,400
2	$17,420	$34,840	$52,260	$69,680	$87,100
3	$21,960	$43,920	$65,880	$87,840	$109,800
4	$26,500	$53,000	$79,500	$106,000	$132,500
5	$31,040	$62,080	$93,120	$124,160	$155,200
6	$35,580	$71,160	$106,740	$142,320	$177,900
7	$40,120	$80,240	$120,360	$160,480	$200,600
8	$44,660	$89,320	$133,980	$178,640	$223,300

Max monthly payment (based on 5% of FPL limit)

Household size	100% FPL,	200% FPL[1]-	300% FPL	400% FPL	500% FPL
1	**$53.67**	**$107.33**	**$161.00**	**$214.67**	**$268.33**
2	$72.58	$145.17	$217.75	$290.33	$362.92
3	$91.50	$183.00	$274.50	$366.00	$457.50
4	$110.42	$220.83	$331.25	$441.67	$552.08
5	$129.33	$258.67	$388.00	$517.33	$646.67
6	$148.25	$296.50	$444.75	$593.00	$741.25
7	$167.17	$334.33	$501.50	$668.67	$835.83
8	$186.08	$372.17	$558.25	$744.33	$930.42

[1] **Families with incomes below 200% FPL are eligible for free care**