Maryland
Hospital Association

April 8, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: <u>Proposed Hospital Payment Plan Guidelines and Workgroup Sessions</u>

Dear Ms. Wunderlich:

On behalf of the Maryland Hospital Association's (MHA) 60 hospitals and health systems, we are commenting on proposed guidelines for hospital payment plans. Under Chapter 770 of the 2021 Laws of Maryland (formerly House Bill 565 and Senate Bill 514), the Health Services Cost Review Commission (HSCRC) is charged with forming guidelines for payment plans hospitals offer to patients who are not eligible for medically necessary free care.

HSCRC released an initial draft in December 2021, followed by public work group meetings in January and February 2022 that included representatives from consumer advocacy groups and hospitals. HSCRC staff used feedback from these meetings to revise its initial draft. Despite our comments at these meetings, MHA remains concerned proposed revisions will increase uncompensated care, causing hospital prices to rise for patients and insurers.

I. Family vs. Individual Gross Monthly Income

Using family income to determine financial assistance and using individual income to determine payment plans creates a cognitive dissidence in payment policies. Although hospital financial assistance policies are separate from payment plans, they intersect when determining whether a patient should be offered a payment plan. A patient who is eligible for free, medically necessary care should not be on a payment plan. To determine financial assistance eligibility, hospitals look at the patient's family income.

Yet, Chapter 770 bases payment plans on the individual patient's federal or state adjusted gross monthly income (GMI). If the policies are not aligned, it creates unanticipated situations of patient versus family income. The patient may not qualify for financial assistance but could technically be exempt from a payment plan without any individual income. **The simple and most effective way to prevent this scenario is to use family income in the guidelines, which HSCRC did in its initial draft.** The new proposed pro rata scheme to allocate individual income within a family is not grounded in existing income determination policies and, if implemented, will place greater burdens on patients and hospitals. While hospitals are happy to work with

patients at any time, making a second determination of income—using a different method than that used to determine financial assistance eligibility—and payment plan limits will discourage patients from following up with the hospital, resulting in more bad debt and collection efforts.

MHA agreed with advocates that hospitals should not have to verify GMI for all patients who seek payment plans. However, the new proposed income determination process pushes hospitals to require more verification as the number of dependents directly affects the monthly amount the hospital can collect from the patient. **MHA urges the Commission to allow patients to self-attest that the payment plan they select will result in monthly payments that are no more than 5% of GMI**. This empowers the consumer to take control of financial responsibilities with minimal intrusion into their personal information, while also ensuring timely closure of outstanding accounts.

II. Proposed 5% Cap on Monthly Payment Plan Installments

Chapter 770 requires HSCRC to create guidelines for the installment payment amount that may not exceed 5% of GMI. However, Chapter 770 also prohibits penalties or fees for prepayment or early payment. Considering these provisions together, **we urge the Commission to ensure guidelines require hospitals to disclose that payment plans cannot by law exceed 5% of GMI, but patients can self-select the plan that best suits their financial needs**.

III. Reasonable Debt Collection Efforts

The Total Cost of Care Model (Model) must be sustained, which requires a delicate balance of generosity with the need to collect. Lower uncompensated care means lower hospital prices for all Marylanders, and charity care is available for patients who need it. HSCRC requires hospitals to make a "reasonable collection effort" before writing off charges.

Prolonged payment plans mean hospitals will record the open balance (i.e., the amount the patient owes) as long as it remains. General accounting standards require hospitals to reserve a larger portion as the balance ages. As a result, uncompensated care reported on the income statement will rise, ultimately raising hospital rates. MHA is extremely concerned that the recommended guidelines will cause bad debts to rise, harming Model performance.

In the late 1980s, this scenario played out in New Jersey. The state's rate-setting system did not have strong incentives to collect outstanding accounts, ultimately raising hospital rates and largely contributing to the end of rate regulation in the state. We strongly encourage the Commission to **balance the proposed payment plan guidelines to safeguard reasonable rates for all payers, including out-of-pocket costs for all patients**.

MHA appreciates the Commission's continued dedication to hospitals and their patients. Thank you for your consideration of our comments

Sincerely,

Brett McCone
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