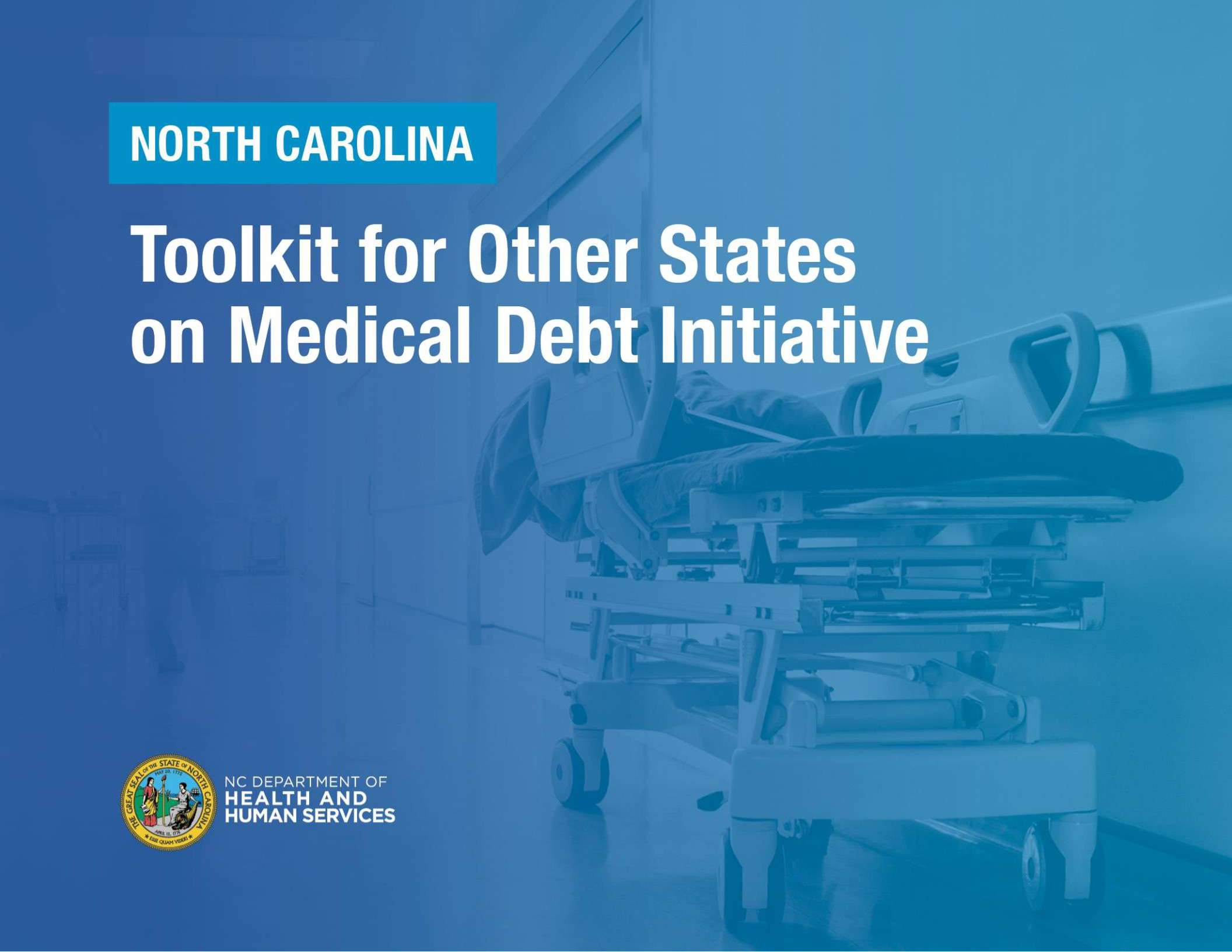
NORTH CAROLINA

Toolkit for Other States on Medical Debt Initiative



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Toolkit for Other States on Medical Debt Initiative Version History				
Date	**Version**	**Description**	**Updates**	**Author**
12.2.24	1.0	Initial Version	N/A	NC DHHS
10.12.26	1.1	In consultation with hospital systems, constituents, and other stakeholders, updated Appendix 2: Hospital Commitment Letter, Medical Debt Mitigation Policies, section 3.A, to include opt-out policy clarification.	Opt-out policy clarification	NC DHHS

Introduction

Over 20 million Americans held $20 billion in outstanding medical debt in 2021.[1] For many low- and middle-income consumers, medical debt causes significant financial distress and can prevent patients from getting the care they need.[2] The problem is particularly pervasive in North Carolina, which has the third highest percentage of households with medical debt in collections among all U.S. states.[3] Recognizing the immense burden on consumers, the North Carolina Department of Health and Human Services (NCDHHS) recently implemented a new program through which hospitals are expected to relieve up to $4 billion in existing medical debt for two million North Carolinians and implement new policies to limit the impact of medical debt in the future. Under this initiative, hospitals are required to adopt medical debt mitigation policies established by the state as a condition for receiving enhanced payments through North Carolina's Medicaid state-directed payment (SDP) program. The Centers for Medicare & Medicaid Services (CMS) approved NCDHHS' SDP proposal in July 2024 and all eligible hospitals have agreed to participate in the initiative.

This toolkit is intended to provide guidance to states interested in pursuing similar policies based on North Carolina's experience, focused on the following key program areas:

- **Structure of SDP arrangement.** Under NCDHHS' initiative, hospitals are required to adopt a set of medical debt mitigation policies in order to receive enhanced payments under North Carolina's Medicaid managed care SDP program. This section details the specific flexibilities under federal Medicaid SDP parameters that NCDHHS leveraged to establish the incentive structure.
- **Medical debt mitigation policies (tied to enhanced payments under SDP program).** NCDHHS incorporated best practices from other states in a comprehensive set of policies that North Carolina hospitals are required to implement as a condition of eligibility for the enhanced payments. This section outlines the specific policies and policy objectives advanced by the state through the medical debt initiative.
- **Interaction with other federal requirements.** This section describes the adjustments NCDHHS made to the policies to mitigate potential financial consequences for hospitals and ensure compliance with federal rules.
- **Communications and stakeholder engagement strategy.** This section addresses how NCDHHS engaged hospitals and other key stakeholders throughout the design process to socialize the state's intended medical debt mitigation policies and solicit feedback. NCDHHS also issued several public-facing communications to build awareness of the program among consumers.
- **Operations**. This section details NCDHHS' approach and rationale for designing key operational components of the program including the implementation of retrospective medical debt relief and development of an effective oversight infrastructure to ensure hospital compliance.

Each section of the toolkit identifies key issues NCDHHS encountered during the program design process, the state's approach to addressing the

[1] "The Burden of Medical Debt in the United States". Peterson-KFF Health System Tracker (February 2024).
[2] "Health Care Debt in The U.S. - The Broad Consequences of Medical and Dental Bills". KFF (June 2022).
[3] "Debt in America". Urban Institute (September 2024).

issue and rationale for the decision. As relevant, the toolkit also links to several resources for states to reference, including:

- Key excerpts of the **Healthcare Access and Stabilization Program (HASP) SDP preprints** establishing the enhanced payment levels for hospitals participating in the initiative.
- The specific **medical debt mitigation policies** that hospitals are required to implement as a condition of enhanced payments under the SDP program**.**
- A **landscape assessment of other states' medical debt mitigation policies** that NCDHHS considered in the design of its program.
- **Press releases and communications related to medical debt initiative** issued by NCDHHS (and other external partners) to socialize and build momentum around the program among consumers and key stakeholders.

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Structure of SDP Arrangement

Overview: NCDHHS received federal approval to condition eligibility for enhanced levels of a state-directed payment (SDP) on hospitals adopting a series of state-defined policies to mitigate the impact of medical debt. Under federal rules, SDPs generally need to be approved by CMS annually and NCDHHS has received approval for the first two years of the program. This section details the specific flexibilities and preprint strategies that NCDHHS used to establish the incentive structure.

Key Issues	North Carolina's Approach	Rationale	Resources
Defining SDP class based on hospital adoption of medical debt policies	• NCDHHS proposed, and CMS approved, an approach whereby hospitals that adopt the state's medical debt mitigation policies become eligible for a separate provider class – and receive enhanced payments for each unit of Medicaid utilization – under the SDP. • To qualify for this separate provider class, hospitals are required to: 1. **Sign and submit a commitment letter** indicating intent to adopt the medical debt mitigation policies in year one of the SDP; 2. **Demonstrate progress toward policy implementation** through reports submitted to NCDHHS in year two of the SDP (and beyond).	• NCDHHS adopted this approach based on CMS guidance and other state precedents. • In the recently released Medicaid Managed Care Final Rule,[4] CMS clarified that states may tie eligibility for SDPs to providers' engagement in state-defined policy initiatives (e.g., health information technology initiatives, participation in learning collaboratives). • CMS has approved SDPs in at least two other states that tie eligibility for the SDP to providers participating in state policy initiatives.[5], [6]	HASP Preprints, Question 20(b)
Establishing differential payment levels for hospitals participating in the medical debt policy	• Hospitals participating in the medical debt initiative will qualify for payments at the average commercial rate (ACR). • Hospitals that do not participate will still receive payments under the SDP but at a lower payment level. • The gap in payment levels between participating and non-participating hospitals increases between year one and two of the program.	• The meaningful difference in payment levels between participating and non-participating hospitals provided a clear incentive for hospitals to adopt the state's policies. • NCDHHS also signaled the differential in payment levels would increase in subsequent years of the program to demonstrate to hospitals the benefit of participation in the program would increase over the long-term.	HASP Preprints, Question 19(d)

[4] Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F).
[5] Illinois State Directed Payment Preprint Approval Letter (CY 2023 rate year).
[6] Tennessee State Directed Payment Approval Letter (CY 2024 rate year).

Key Issues	North Carolina's Approach	Rationale	Resources
initiative vs. those that do not			

Medical Debt Mitigation Policies (Tied to Enhanced Payments Under SDP Arrangement)

Overview: NCDHHS leveraged best practices from other states, discussions with experts in the field, and engagement with hospitals and other stakeholders to identify opportunities for addressing the problem of medical debt in North Carolina. These efforts culminated in a comprehensive set of policies that combines one-time, retrospective medical debt relief with longer-term prospective solutions that collectively shield low- and middle-income consumers from medical debt in the future. This section describes the specific policies NCDHHS established, based on other state examples, that hospitals are required to adopt as a condition of enhanced payments under the SDP program.

Key Issues	North Carolina's Approach	Rationale	Resources
Retrospective Medical Debt Mitigation			
Providing one-time relief of low and middle-income consumers' past medical debt	• Hospitals are required to partner with a nonprofit third-party vendor to facilitate forgiveness/donation of all medical debt dating back to January 1, 2014 for Medicaid enrollees and other patients with incomes at or below 350% FPL or medical debt above 5% of income.	• Several states (including Arizona, New Jersey, Connecticut, Illinois, and Pennsylvania) have forgiven billions of dollars in medical debt, often leveraging federal funds available during the COVID-19 public health emergency.[7] • NCDHHS' policy eliminates past medical debt for those newly eligible under the state's recent Medicaid expansion, as well as other low- and moderate-income consumers.	Hospital Commitment Letter, Policy 1 Summary of Other State Policies
Prospective Medical Debt Mitigation			
Developing minimum standards for	• NCDHHS reviewed charity care policies across major North Carolina hospital systems and identified significant variability in eligibility	• NCDHHS identified several states (including Maryland, New Mexico, and Washington) that passed laws establishing minimum	Hospital Commitment Letter,

[7] "Vice President Harris Announces Proposal to Prohibit Medical Bills from Being Included on Credit Reports". The White House (2024)

Key Issues	North Carolina's Approach	Rationale	Resources
hospital charity care policies	criteria and discounts offered to patients. • Under the state initiative, hospitals must, at minimum, provide discounts on medical bills of between 50-100% for patients with incomes at or below 300% FPL, with the amount of the discount varying based on the patient's income.	requirements for hospitals' charity care policies.[8] • NCDHHS established minimum standards for hospitals' charity care policies that generally align with more generous policies offered among North Carolina hospitals in order to extend similar benefits to consumers statewide.	Policy 2 Summary of Other State Policies
Ensuring patients can access discounts for which they are eligible	• NCDHHS will require that hospitals implement processes to proactively screen patients for eligibility for financial assistance (instead of requiring that patients request and submit an application). Specifically, hospitals are required to implement: 1. **Presumptive eligibility based on non-income factors** in year one of the SDP, extending eligibility to individuals experiencing homelessness, patients with mental incapacitation with no one to act on their behalf, and patients in a means-tested public assistance program (e.g., WIC, SNAP); 2. **Income-based presumptive eligibility** in year two of the SDP, extending eligibility to individuals with incomes at or below 300% FPL. • Hospitals may use internal data and/or third-party software tools or services to verify patient income but may not require patients to provide documentation.	• Today, individuals who are eligible for financial assistance frequently fail to benefit for a variety of reasons, including high barriers to participation and lack of knowledge about financial assistance programs.[9] • Several North Carolina hospitals previously offered presumptive eligibility for charity care on a voluntary basis, meaning precedent for the policy already existed in the state. • At least one other state (Illinois) has required hospitals to implement presumptive eligibility for financial assistance.[10]	Hospital Commitment Letter, Policy 3 Summary of Other State Policies

[8] "State Protections Against Medical Debt". The Commonwealth Fund (September 2023).
[9] "Patients Eligible For Charity Care Instead Get Big Bills". KFF Health News (October 2019).
[10] Illinois Administrative Code Title 77 § 4500.40

Key Issues	North Carolina's Approach	Rationale	Resources
Restricting hospital billing and collections practices posing financial / legal hardship on consumers	• Hospitals are prohibited from selling medical debt to third-party collections agencies for patients with incomes at or below 300% FPL, reporting patients' debt to credit agencies, and conducting any collections practices that result in legal actions or financial penalties (among other requirements).	• Leveraging best practices from other states, NCDHHS' restrictions on billing / collections practices provide protections for patients eligible for charity care as well as those who are not, extending robust protections not previously available to consumers in North Carolina.	Hospital Commitment Letter, Policies 4-9 Summary of Other State Policies

Interaction of Medical Debt Policies with Federal Requirements

Overview: Stakeholders raised concerns regarding unintended financial consequences of the medical debt mitigation program and potential non-compliance with federal rules. NCDHHS addressed these issues through due diligence and proactive engagement with federal partners.

Key Issues	North Carolina's Approach	Rationale	Resources
Minimizing hospital concerns related to reduction in Medicare bad debt reimbursement	• Today, hospitals are reimbursed for a portion of their Medicare bad debt. Several North Carolina hospitals raised concerns they would lose out on this revenue stream under the state's initiative. • NCDHHS designed its one-time medical debt relief policy to have virtually no impact on hospitals' Medicare bad debt reimbursement because: (i) hospitals report bad debt through annual Medicare cost reports and are likely to have already claimed reimbursement for the vast majority of years dating back to the January 1, 2014 effective date for the policy; ***and*** (ii) the donation of any Medicare patients' accounts would not result in any income that hospitals would need to offset against Medicare bad debt reimbursement.[11] • While hospitals (going forward) will not be able to claim bad debt for Medicare patients receiving charity care under NCDHHS policies, Medicare bad debt reimbursement is a nominal share of North Carolina hospitals' net patient service revenue (<1%) and any reduction in these payments would be small compared to the increase in payments under the SDP program.	• NCDHHS designed policies to mitigate hospitals' concerns related to unintended financial impacts of the medical debt mitigation initiative on other sources of hospital revenue to minimize barriers to participation in the state initiative.	N/A
Addressing concerns related to federal fraud & abuse laws	• Hospitals questioned whether NCDHHS' medical debt initiative would violate beneficiary inducement restrictions under the Anti-Kickback Statute (AKS) and Civil Monetary Policies (CMP) Law, which are intent-based prohibitions on the transfer of renumeration that is likely to influence consumers' choice or referral patterns for services covered	• NCDHHS made every effort to validate all aspects of its policy initiative were compliant with federal rules and requirements,	N/A

[11] Federal Medicare rules at 42 CFR § 413.89 establish minimum requirements providers must meet before claiming Medicare bad debt reimbursement, including that: (1) The debt must be related to covered services and derived from deductible and coinsurance amounts; (2) the provider must be able to establish that reasonable collection efforts were made for beneficiaries classified as non-indigent; (3) the debt was actually uncollectible when claimed as worthless; and (4) sound business judgment established that there was no likelihood of recovery at any time in the future.

Key Issues	North Carolina's Approach	Rationale	Resources
	by federal healthcare programs.[12] • NCDHHS proactively consulted and validated with the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) that hospitals would not run afoul of AKS or CMP prohibitions by participating in the medical debt initiative. • Specifically, HHS-OIG opined that NCDHHS' initiative posed little risk in violating federal fraud/abuse laws since hospitals' implementation of policies would be: (i) motivated by participation in a state initiative rather than inducing referrals; (ii) unlikely to influence consumer choice or referral patterns since retrospective debt relief would occur after the consumer's choice of a provider and prospective charity care policies would likely become standardized across the state; (iii) unlikely to pose risk of overutilization among federal healthcare program beneficiaries since policies apply broadly to all patients based on income and across hospital IP/OP services.	providing broader assurances for hospitals to participate.	
Adjusting policies to align with EMTALA anti-discrimination provisions	• Under NCDHHS' preliminary draft policy, hospitals were required to conduct screenings for presumptive eligibility for charity care at check-in across all hospital settings. • Hospitals were concerned that this requirement, applied in the ED setting, may not comply with the Emergency Medical Treatment and Labor Act (EMTALA) statute that prohibits against discrimination based on ability to pay.[13] • NCDHHS revised its policy to require screenings for patients admitted in the ED as soon as possible after receipt of health care services and prior to initial bill.	• NCDHHS solicited hospital input early and often throughout the design process, and incorporated hospital feedback when aligned with state policy goals.	N/A

[12] Fraud & Abuse Laws, HHS Office of Inspector General

[13] CMS-1063-F

Communications and Stakeholder Engagement Strategy

Overview: NCDHHS implemented a deliberate strategy for soliciting feedback and communicating key programmatic developments to key stakeholders throughout the process.

Key Issues	North Carolina's Approach	Rationale	Resources
Ensuring hospital buy-in and operational feasibility	• NCDHHS maintained close contact with a diverse group of hospitals throughout the design and implementation process and provided multiple opportunities for hospitals to provide written feedback on proposed program design. • NCDHHS consulted external subject matter experts on hospital finance and revenue cycle to deliberate and address operational and financial concerns raised by hospitals during the proposal development process.	• Hospital associations can be a helpful facilitator and convener on issues shared among hospitals across the state. Given that certain policies can impact individual facilities differently, NCDHHS engaged extensively with individual hospitals and health systems to address concerns. • Approach allowed the state to vet and refine proposed policies and secure hospitals' commitment to participate.	N/A
Amplifying the consumer experience and promoting awareness of medical debt policy initiative among consumers	• NCDHHS issued a series of press releases and public statements leading up to (and after) CMS' approval of the SDP proposal. • NCDHHS also met directly with consumers and consulted the American Cancer Society and Leukemia & Lymphoma Society to spotlight personal accounts of the impact of medical debt and benefits of the state's medical debt initiative on consumers.	• NCDHHS publicly announced key components of the program at critical junctures in stakeholder negotiations, which encouraged consumer advocates to offer public support. • Consumers (and consumer advocates) are promoting program eligibility/benefits as hospitals begin implementation to ensure hospitals honor their commitments and consumers are aware of the new opportunities.	*Appendix: Press Releases*
Partnering with trusted messengers to amplify and build momentum around NCDHHS'	• NCDHHS pursued several channels to promote its initiative to the broader health policy community, including: 1. Publishing an overview of the initiative in a Health Affairs Forefront article.	• Approach allowed for greater visibility and for NCDHHS to frame the narrative around its objectives / initiative.	*Appendix: Press Releases*

Key Issues	North Carolina's Approach	Rationale	Resources
policy objectives	2. Providing information to leading health policy (e.g., KFF) and local media, which devoted high-profile coverage to the initiative. 3. Relying on external partners (e.g., NC Justice Center, Dollar For) to promote NC's medical debt initiative locally (in addition to their support for program implementation).		

Operations

Overview: Successful launch of North Carolina's medical debt initiative required navigating a range of complex and challenging operational issues.

Key Issues	North Carolina's Approach	Rationale	Resources
Identifying workable approaches for hospitals to operationalize retrospective debt relief	• North Carolina will require that hospitals work with Undue Medical Debt (or another approved nonprofit vendor) to effectuate one-time debt forgiveness. • The state will also allow hospitals to effectuate ongoing debt relief for Medicaid enrollees by reclassifying debt as charity care.	• Undue Medical Debt has significant expertise in working with hospitals to identify and relieve uncollectible medical debt, which streamlines administrative burden for hospitals and the state and provides a meaningful measure of accountability over the debt relief process. • Allowing hospitals to reclassify debt as charity care for Medicaid enrollees will similarly provide relief to patients without any tax implications; it will also expedite the debt relief process for the state's poorest individuals.	N/A
Establishing appropriate Departmental oversight	• Hospitals are eligible for enhanced payments under the SDP program by completing the following: – **Year One**: Submission of a formal	• NCDHHS developed mechanisms for program oversight to ensure accountability while limiting the administrative burden for the state	N/A

Key Issues	North Carolina's Approach	Rationale	Resources
	commitment letter to NCDHHS indicating the hospital's intention to adopt the state's medical debt mitigation policies, – **Year Two (and Beyond)**: Submission of bi-annual reports to NCDHHS demonstrating implementation of key program milestones and providing data for key debt relief metrics to monitor the impact of these policies on consumers. • In addition to demonstrating compliance with meeting effective dates for medical debt mitigation policies, hospitals must also report: 1. Number of consumers impacted by retrospective debt relief and the aggregate amount of medical debt relieved (relative to baseline prior to implementation of NCDHHS policies); 2. Number of consumers receiving charity care based on income-based and non income-based presumptive eligibility by income range (relative to baseline prior to implementation of NCDHHS policies); 3. Number of financial assistance applications received and approved for patients by income band (i.e., 0-200% FPL, 200-250% FPL, 250-300% FPL); 4. Cost of charity care provided as a percent of total hospital costs.	and hospitals.	

Appendix 1: Healthcare Access and Stabilization Program (HASP) SDP Preprints

Links to Full SDP Approval Letters

- HASP SDP Preprint Approval Letter (SFY 2024)
- HASP SDP Preprint Approval Letter (SFY 2025)

Relevant Excerpts from SDPs

SFY 2024 HASP PREPRINT (YEAR 1)

Question		Preprint Response
19(d)	Describe how the [uniform] increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract.	For each class identified in response to Question 20(b), [NCDHHS' Division of Health Benefits] (DHB) calculated Payment Increase Percentages for inpatient and outpatient services based on the projected additional payments needed for each hospital class to receive reimbursement equivalent to a specified share of the average commercial rate […] DHB developed separate inpatient and outpatient Payment Increase Percentages using estimates derived from HCRIS data. DHB identified the payment equivalent for commercial managed care payers for inpatient and outpatient services and each provider class and calculated the **total payments needed for each provider type to receive 100% of commercial-equivalent payments**. DHB then determined uniform Payment Increase Percentages for inpatient and outpatient services for each hospital class by dividing each class's total inpatient and outpatient directed payment amounts by corresponding estimated Medicaid Managed Care Payments (excluding other state directed payments) for the hospital class. **These Percentages are applicable to Classes 1b and 2b**. **For Classes 1a and 2a, DHB applied a discount factor of 79% to the Payment Increase Percentages applicable to Classes 1b and 2b**.
20(b)	Please define the provider class(es).	Class 1 includes hospitals owned or controlled by the University of North Carolina Health Care System (UNCHS) and Vidant Medical Center (d/b/a ECU Health Medical Center). Class 2 includes acute care hospitals and critical access hospitals not included in Class 1. Class 1a/2a: Hospitals within each respective class (described above) that do not commit to implementing medical debt mitigation policies specified by the North Carolina Department of Health and Human Services (DHHS). Class 1b/2b: Hospitals within each respective class that do **commit to implementing medical debt mitigation policies** specified by DHHS.

SFY 2025 HASP PREPRINT (YEAR 2)

Question		Preprint Response
19(d)	Describe how the [uniform] increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract.	For each class identified in response to Question 20(b), [NCDHHS' Division of Health Benefits] (DHB) calculated Payment Increase Percentages for inpatient and outpatient services based on the projected additional payments needed for each hospital class to receive reimbursement equivalent to a specified share of the average commercial rate […] DHB developed separate inpatient and outpatient Payment Increase Percentages using estimates derived from HCRIS data. DHB identified the payment equivalent for commercial managed care payers for inpatient and outpatient services and each provider class and calculated the total payments needed for each provider type to receive 100% of commercial-equivalent payments. DHB then determined uniform Payment Increase Percentages for inpatient and outpatient services for each hospital class by dividing each class's total inpatient and outpatient directed payment amounts by corresponding estimated Medicaid Managed Care Payments (excluding other state directed payments) for the hospital class. These Percentages are applicable to Classes 1b and 2b. **For Classes 1a and 2a, DHB applied a discount factor of 52% to the Payment Increase Percentages applicable to Classes 1b and 2b**.
20(b)	Please define the provider class(es).	Class 1 includes hospitals owned or controlled by the University of North Carolina Health Care System (UNCHS) and Vidant Medical Center (d/b/a ECU Health Medical Center). Class 2 includes acute care hospitals and critical access hospitals not included in Class 1. Class 1a/2a: Hospitals within each respective class (described above) that do not submit a report documenting implementation of medical debt mitigation policies specified by the North Carolina Department of Health and Human Services (DHHS). Class 1b/2b: Hospitals within each respective class that do submit a **report documenting implementation of medical debt mitigation policies** specified by DHHS.

Appendix 2: Hospital Commitment Letter, Medical Debt Mitigation Policies

#	Topic	Policy Requirement	Effective Date
Provide Immediate Relief to Consumers			
1	**Medical Debt Relief/Donation**	a. The Institution shall relieve/donate all unpaid patient medical debt dating back to January 1, 2014 for North Carolina residents who are currently enrolled in Medicaid (including in limited benefit family planning coverage).[14] i. The Institution shall evaluate patient accounts with outstanding balances for current Medicaid enrollment, and reclassify debt for such individuals dating back to January 1, 2014 as charity care. For purposes of this requirement, debts reclassified as charity care will be considered relieved. ii. This requirement shall apply to any debts subject to a payment plan previously agreed to by the patient. b. Beginning July 1, 2025 and thereafter, the Institution shall evaluate all patients who are North Carolina residents and enrolled in Medicaid for past medical debt within 60 days of the patient's inpatient discharge or outpatient encounter from the hospital, and must reclassify any past debt as charity care. i. The Institution shall not advertise about the policy but must inform the Medicaid-enrolled patient about the policy during the patient's encounter at the hospital.[15] ii. In addition, the Institution must reclassify as charity care any past debt of Medicaid-enrolled patients that proactively contact the hospital to inquire about medical debt relief. iii. The Institution may confirm the patient's Medicaid enrollment prior to reclassifying past debt as charity care.	Requirements 1.a-1.c, 1.e, 1.h: By July 1, 2025 Requirement 1.d: To be defined by the Department but no earlier than June 30, 2026 Requirement 1.f: October 1, 2024 Requirement 1.g: March 1, 2025 Requirement 1.i-1.j: Immediately

[14] "Current" means the individual was enrolled in Medicaid at the time the Institution or a third-party analyzed data identifying patient accounts eligible for reclassification of debt as charity care.

[15] The Office of the Inspector General at the federal Department of Health and Human Services (OIG HHS) clarifies that making all patients aware of a financial assistance policy on its website does not necessarily constitute an advertisement or solicitation. See Frequently Asked Questions, 7/8/2024, Question 14.

#	Topic	Policy Requirement	Effective Date
Prevent Accumulation of Debt[16]			
2	**Medical Debt Mitigation Policy**	a. The Institution shall develop a written Medical Debt Mitigation Policy (MDMP), including (but not limited to) a financial assistance policy with eligibility criteria, screening and presumptive eligibility approach and a billing/collections policy. b. For inpatient and outpatient hospital services[17], the Institution's MDMP Policy shall include the following: i. Discount of 100% for individuals with incomes below 200% FPL. ii. Discount of at least 75% for individuals with incomes between 200% – 250% FPL. iii. Discount of at least 50% for individuals with incomes between 250% - 300% FPL. iv. Discounts must be applied to the amount the patient owes (i.e. accounting for contractual allowances and insurance payments, if applicable) or the "amount generally billed" for uninsured individuals.[18] v. Discounts must apply consistently to uninsured and insured individuals and to all NC residents. c. Notwithstanding requirement 2.b, for emergency department services, the Institution may collect a fee from insured and uninsured patients that is the greater of (1) the amount the patient would owe based on the percentage discounts specified in requirement 2.b, and (2) $35, not to exceed cost-sharing under the patient's health plan (for insured patients). d. For individuals with incomes between 200 - 300% FPL, the Institution must offer a payment plan that does not exceed a duration of 36 months with monthly payments no greater than 5% of monthly household income ("36 month/5% income plan"). The Institution may offer alternative payment plans that exceed 36 months, but the aggregate amount collected from the patient—inclusive of principal and interest—shall not exceed what would have been collected under the 36 month/5% income plan. e. The Institution's MDMP will be publicized in a variety of formats/languages and made available to individuals who receive care from the facility; MDMPs should be written in	January 1, 2025

[16] Note: policies designed to prevent accumulation of debt and mitigate problematic debt collection practices are required to apply to North Carolina residents. Hospitals may choose to extend policies to non-residents.

[17] Discounts may be limited to inpatient and outpatient hospital facility claims (e.g. can exclude retail pharmacy and / or professional services).

[18] As required under Section 501(r) of the Internal Revenue Code, for emergency and medically necessary services, nonprofit hospitals may not charge individuals eligible for the hospital's financial assistance policy more than the "amount generally billed" (AGB) to individuals who have insurance covering such care.

#	Topic	Policy Requirement	Effective Date
		plain language accessible to patients. The hospital's homepage must include a link to the MDMPs. f. The Institution is not required to apply discounts to co-pays of insured individuals. g. Third party debt collectors contracting with the Institution shall make debtors aware of MDMP/hospital financial assistance policies. h. The Institution's financial assistance policies shall cover all medically necessary services and shall not be required to cover costs associated with cosmetic surgery, as defined by DHB Clinical Coverage Policy No: 1-O-1.	
3.A	**Presumptive Eligibility for Financial Assistance**	a. The Institution shall develop a Presumptive Eligibility (PE) for Financial Assistance Policy describing processes for screening patients to determine inability to pay for services. b. The Institution shall include its policy for communicating PE opt-out and opt-in policies within the Institution's MDMP; within its patient portal; verbally during the appointment, where feasible; and as described in 2.e. of this document. c. The Institution's PE Policy shall not require a patient to provide documentation or other verification of meeting eligibility criteria. d. The Institution must provide an alternative pathway for patients who are not deemed presumptively eligible for financial assistance. Documentation may be submitted as part of this alternative pathway. e. The Institution may implement Medicaid PE for individuals who attest to qualifications or are found qualified with the understanding they will not be held financially liable if the individual is later determined ineligible. f. Financial assistance policy requirements shall not apply to costs associated with cosmetic surgery, as defined by DHB Clinical Coverage Policy No: 1-O-1. g. The Institution shall allow a patient to opt-out from PE, including prior to screening or after a presumptive eligibility determination has been made. i. The MDMP section on PE should include information on what it means to be screened, that screening is done presumptively using screening questions, available data or via third-party tools, that patients can choose to opt-out of PE screening, and the process for opting out. ii. Institutions may determine the process for allowing patients to opt out of PE screening, both before and after screening. Acceptable methods may include electronic options, such as MyChart or another patient portal; verbal consent during appointments; or written materials provided during patient registration. iii. The patient's decision to opt out of PE screening must be documented in the	Requirements 3.A.a, 3.A.c, 3.A.d, 3.A.e, 3.A.f: January 1, 2025 Requirements 3.A.b, 3.A.g: January 1, 2027

#	Topic	Policy Requirement	Effective Date
		Institution's records. iv. Institutions may choose to apply a patient's decision to opt out to all future visits (provided the patient does not opt back into PE) or may present patients with the opportunity to be screened or opt out each time they seek care. v. Institutions that carry forward a patient's opt-out election beyond the current visit shall maintain a process that allows the patient to opt back into PE screening at any time. The Institution shall describe this process in its MDMP and patient-facing materials. vi. For patients seeking to opt-out of PE, the Institution shall clearly notify the patient of the following prior to the opt-out becoming effective: a. Whether the opt-out applies only to the current visit or will remain in effect for future visits. If the opt-out applies to future visits, the Institution shall specify for how long the opt-out election remains in effect and the process for a patient to opt back into PE. b. That the patient may apply for financial assistance through the Institution's standard financial assistance application process at any time, regardless of whether the patient has opted out of PE screening. c. For patients electing to opt out of PE, whether the Institution will allow for financial assistance to be applied retrospectively if the patient decides at a later date to opt back into PE (or completes a standard financial assistance application). d. For patients opting out before screening, that the PE screening is provided at no cost to the patient and that the patient may instead choose to proceed with screening and make a decision about opting out after receiving the screening result (as applicable).	
3.B	**Presumptive Eligibility for Financial Assistance: Non-Income-Based Criteria**	a. The Institution shall implement policies where patients are deemed presumptively eligible for financial assistance based on certain non-income-based criteria. These criteria include the following (patients must meet at least one): i. Homelessness; ii. Mental incapacitation with no one to act on the patient's behalf; iii. Enrollment in Medicaid of patient or a child in their household; iv. Enrollment in another means-tested public assistance program (including, but not limited to Women, Infants and Children Nutrition Program, Supplemental Nutrition Assistance Program).	January 1, 2025

#	Topic	Policy Requirement	Effective Date
		b. The Institution shall screen patients for non-income based PE and notify patients of results based on the following timeline: i. *Non-emergency department services:* A. Screening: Prior to or at check in. B. Notification: Prior to discharge. ii. *Emergency department services:* A. Screening: As soon as possible and prior to discharge if feasible. B. Notification: Prior to issuing bill to patient.	
3.C	**Presumptive Eligibility for Financial Assistance: Income-Based Criteria**	a. The Institution shall implement policies where patients are deemed presumptively eligible for financial assistance if they have household income up to 300% of FPL (if they do not already meet non-income-based criteria described above). The Institution may use third-party software tools or services to verify patient eligibility for income-based PE. b. The Institution shall provide notification of income-based PE prior to issuing a bill to the patient. c. Prior to implementation of this requirement, DHHS will identify best practices related to PE for hospital financial assistance to inform hospitals' selection of PE vendors.	January 1, 2026
4	**Medical Debt Interest Rate Cap**	a. The interest rate for all medical debt held directly by the Institution shall be capped at 3%. b. All medical debt sold to third party debt collectors shall have interest rates capped at the Secured Overnight Financing Rate (SOFR) plus one percentage point.	July 1, 2025
Mitigate Problematic Debt Collection Practices			
5	**Limiting Sale of Debt to Third Parties**	a. The Institution shall not sell debt to third-parties prior to 120 days after the first bill has been sent to the patient. b. The Institution shall not sell debt to third parties for individuals with incomes up to 300% of FPL, unless for the purpose of relieving the debt. c. The Institution may enter into arrangements with a third party to manage debt collection activities, provided that the Institution maintains ownership of the debt; the Institution must ensure that all contracted debt collection entities comply with all requirements applicable to the Institution described herein.	July 1, 2025
6	**Billing/Collections Rules**	a. Medical creditors/debt collectors (including the Institution and any contracted third party collection agencies) will not take any of the following actions to collect medical debt: i. Causing an individual's arrest.	July 1, 2025

#	Topic	Policy Requirement	Effective Date
		ii. Causing an individual to be held in civil contempt or imprisoned. iii. Foreclosing on an individual's real property. iv. Garnishing wages or State income tax refunds. b. Medical creditors/debt collectors will not engage in any permissible extraordinary collection actions until 180 days after the first bill for a medical debt has been sent.[19] c. Medical creditors/debt collectors will provide patients with 30 days notice of any extraordinary collection actions. d. Hospitals (and their debt collectors) will reverse any extraordinary debt collection actions if a patient is later found to be eligible for financial assistance.	
7	**Reporting Medical Debt to Credit Agencies**	a. The Institution and contracted collections agencies will not report a patient's debt to a credit reporting agency. b. Previous reports to credit reporting agencies will be taken back if the debt has been forgiven.	July 1, 2025
8	**Liability for Medical Debt**	a. No individual—except for spouses—will be held liable for medical debt owned by the Institution or sold to third parties of any other person ages 18 or older (individuals may voluntarily assume liability). b. A spouse held liable for a patient's medical debt will be eligible for the same medical debt mitigation policies offered to the patient.	July 1, 2025
Maintenance of Effort			
9	**Insurance Appeals**	a. Medical creditors/debt collectors will not initiate legal action against a patient for any claims where an insurance appeal/review is pending within the previous 60 days. b. Medical creditors will not refer debts to an external debt collector if an insurance appeal/review was pending within the previous 60 days.	July 1, 2025
10	**Maintenance of Effort**	a. The Institution's policies related to items 1-9 above must be at least as generous as any policies in place as of March 1, 2024, even if the Institution's policy is more generous than the minimum standards prescribed above.	Immediately

[19] An extraordinary collection action includes any of the following: selling an individual's debt to another party, except if prior to the sale, the medical creditor enters into a legally binding written agreement with the medical debt buyer establishing certain patient protections related to the debt collection; reporting adverse information about the patient to a consumer reporting agency; actions that require a legal or judicial process (e.g., placing a lien on an individual's property, commencing a civil action).

Appendix 3: Landscape Assessment of Other States' Medical Debt Mitigation Policies

Policy Area	Issue	State Examples
Provide Immediate Relief to Consumer	Individuals with significant **outstanding debts**	• Require hospitals to **forgive all existing medical debt for individuals with incomes up to 400% of FPL** and **those with debt totaling 5x annual income** *(DC, Cook County, IL)*
Prevent Accumulation of Debt	Individuals with **limited/no ability to pay accruing debts** to begin with	• Require hospitals to **develop a sliding scale financial assistance policy providing reduced cost care to individuals with incomes up to 400% of FPL** *(MD)***.** Department would review policies and determine whether to be more prescriptive in future years. • Require hospitals to **screen for insurance, financial assistance, or charity care eligibility (***NM, WA)*
	High interest rates on medical debt	• **Cap medical debt interest** rates at **the federal funds rate + 3 percentage points** (prime rate) *(~AZ, CO, ND, WA)* • **Cap medical debt interest** rates at **the federal funds rate + 5 percentage points** (prime rate + 2 percentage points) *(~AZ, CO, ND, WA)*
Mitigating Problematic Debt Collection Practices	Hospitals **suing patients**	• **Prohibit lawsuits related to medical debt for individuals with incomes up to 400% of FPL** *(~IL)*
	Hospitals **selling debt to debt collectors**	• **Prohibit selling debt prior to 120 days** after the first bill has been sent to patient *(MA)*. • **Prohibit selling debt for individuals with incomes up to 200% of FPL** *(~CT, MA, NJ, NM)* • Require hospitals to establish contracts with third party debt collection agencies ensuring that the agency will **abide by a standardized set of collections policies*** *(MA)*
	Hospitals **reporting patient medical debt to credit agencies**	• **Prohibit reporting a patient's debt** to a credit reporting agency *(MN)* • **Prohibit reporting a patient's debt** to a credit reporting agency unless specifically **approved by the hospital's board of directors** *(MA)*. • **Require hospitals to seek removal of information** previously reported to consumer reporting agency from **the patient's credit report** once the debt is paid in full *(MA)*.

Appendix 4: Press Related to NCDHHS' Medical Debt Initiative & Related Efforts Nationwide

NCDHHS Press Releases & Fact Sheets

- Initial press release and FAQ to announce NCDHHS' initiative subsequent to NCDHHS' submission of SDP preprint to CMS
- Follow-up press release on NCDHHS' roundtable on medical debt relief
- Follow-up press release to indicate CMS approval of NCDHHS' SDP proposal
- Recent press release to indicate all 99 hospitals eligible for NC's hospital SDP agreed to participate in NCDHHS' medical debt initiative

External Publications on NCDHHS' Medical

- Health Affairs Forefront: "How State Policy Makers Can Tackle Medical Debt: Lessons From North Carolina"
- KFF: "North Carolina's Effort to Relieve Medical Debt"
- North Carolina Justice Center: "Medical Debt in North Carolina"
- American Cancer Society: "American Cancer Society Cancer Action Network Applauds State Leaders for Commitment to Alleviate Medical Debt in North Carolina"

Additional References & Data Points NCDHHS Leveraged for Stakeholder Engagement

- Healthcare Financial Management Association: "Reimagining Charity Care: How Monument Health Puts Patients First with an Innovative Financial Assistance Program"
  - *Note*: The example of a rural health system voluntarily developing and adopting a robust presumptive eligibility for charity care policy was a helpful example for NCDHHS in negotiations with North Carolina hospitals.
- Dollar For: "Pointless Debt: How Oregon Hospitals Skirt Financial Assistance Laws to Charge Patients – Without Increasing Revenues"
  - *Key Data Point*: Revenue generated from self-pay patient accounts amounts to only 1.6% of hospital revenue in Oregon.
- Leukemia and Lymphoma Society: "LS Teams Up with Advocates to Advance Policies that Protect Patients from Medical Debt"
  - *Key Data Point*: 9 in 10 adults in the U.S. support policies protecting people with serious illnesses from medical debt.