Maryland
Hospital Association

September 7, 2021

Submitted via Regulations.gov

Xavier Becerra
Secretary
Department of Health and Human Services

Ali Khawar
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Mark J. Mazur
Acting Assistant Secretary of the Treasury
(Tax Policy)

Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service

Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

Re: Requirements Related to Surprise Billing: Part 1 (Interim Final Rule)

Dear Mr. Becerra, Mr. Khawar, Mr. Mazur, Mr. O'Donnell, and Ms. Bodenheimer:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the first set of regulations implementing the No Surprises Act. MHA is dedicated to protecting patients from gaps in their health coverage that result in unexpected medical bills and looks forward to working with the departments as they promulgate additional regulations.

All Maryland hospitals are considered in-network for major health insurance plans subject to Maryland law. Under the Total Cost of Care Model, Maryland's hospitals are committed to reducing health care spending through all-payer and global budget revenue payment methodologies. Hospital prices are set by the Health Services Cost Review Commission (HSCRC), an independent state agency. HSCRC and its sister agency, the Maryland Health Care Commission (MHCC), then share the information regarding hospital services costs publicly. This means health care consumers in Maryland can preemptively identify the amount their insurance carrier will pay for the hospital service and thus calculate anticipated cost-sharing based on their coverage.

MHA recognized the importance of protecting patients from balance billing for emergency care and advocated for legislation to expand options to protect consumers from surprise bills. Using assignment of benefits, out-of-network providers can agree to have the insurer pay the doctor directly, rather than requiring the doctor to balance bill the patient. However, even with these

measures, we believe network adequacy is critical to protect patients from surprise medical bills. Full provider panels, accurate provider directories, and competitive reimbursement rates are integral to ensure patients get the full value of their comprehensive coverage—including plans regulated under ERISA. We urge the departments to work with Congress to establish network adequacy requirements where they do not exist (i.e., ERISA).

MHA generally echoes comments submitted by the American Hospital Association (AHA) and supports the departments' continued efforts to protect patients from surprise billing due to inadequate insurance coverage.[1] However, several issues are of particular interest to MHA members:

I. Prohibition on Emergency Claim Denials Solely Based on Diagnosis Codes

MHA appreciates the departments' unequivocal assessment that certain health insurer practices of denying coverage for emergency medical services is inconsistent with the Affordable Care Act's prudent layperson standard, as well as the No Surprises Act. Members have already raised concerns with certain insurers' proposed policies, which may allow them to retroactively deny emergency room visits. The prohibition established in the regulations is a relief; we look forward to the departments' continued work to ensure insurers do not implement such policies. We support regulations to address misguided insurer proposals that deter patients from seeking the care they need.

II. Consideration of the Maryland Total Cost of Care Model for Calculating Patient Cost-Sharing

MHA appreciates the consideration of Maryland's Total Cost of Care Model, along with other all-payer models, to determine the recognized amount and out-of-network rate. Requiring all payers to pay the same amount determined by HSCRC for regulated hospital charges is an integral part of the Maryland Total Cost of Care Model and critical to its success. However, it is our understanding that charges for services performed in unregulated spaces (e.g., freestanding physicians' offices and ambulatory surgical centers that are part of a health system) will be subject to the qualifying payment amount (QPA) to determine the recognized amount and out-of-network costs. We support AHA's concerns regarding transparency in the insurers' calculations for QPA, as well as oversight of the insurers' methodology and data for those calculations.

III. Notice and Consent for Waiving Balance Billing Provisions

MHA is concerned that the notice and consent requirements will be an administrative burden for the patient and the provider. Paperwork associated with patient visits has grown exponentially, frustrating patients, who are asked to continuously sign—and in many cases, re-sign—documents prior to receiving needed care. We recognize the importance of notifying and receiving consent from patients about the possibility of being balance billed for services, but we

[1] Submitted September 1, 2021 (aha.org/lettercomment/2021-09-01-aha-letter-requirements-related-surprise-billing-part-i-september-1-2021).

would appreciate additional consideration of the following items, as they pose significant logistical and operational barriers that are not in the spirit of the health care field's commitment to putting patients before paperwork.

- *Physically Separate Documents:* The regulations require providers and facilities to convey the forms to the patient separately from other documents. The regulations clarify that the notice and consent forms must be provided together, but "given physically separate from, and not attached to or incorporated into any other document." We believe this requirement poses operational barriers that are greater than the benefit intended.

- *Three-Hour Waiting Period for Same-Day Services:* As providers dedicated to ensuring patients are treated compassionately, the three-hour waiting period between the patient's consent and when treatment may be administered is not practical and costly if the patient must remain in the facility the entire time. We support AHA's request to address likely common instances where the provider gives notice and the patient immediately consents and to allow the provider to deliver care as soon as possible.

- *Frequency of Notice and Consent Signatures:* MHA members serve many patients with recurring scheduled visits (e.g., cancer patients obtaining multiple rounds of treatment). Requiring these patients to receive the notification and sign the consent form for each visit creates duplicative efforts without resulting benefits. We respectfully request an exception in the notice and consent provisions to ease this requirement for patients with repeated scheduled visits.

MHA appreciates the departments' dedication to protecting patients from surprise medical billing due to coverage gaps. We look forward to seeing the departments' responses to our feedback as we strive for successful implementation.

Sincerely,

Nicole Stallings
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Senior Vice President, Government Affairs & Policy