Maryland
Hospital Association

November 16, 2022

Megan Renfrew
Associate Director of External Affairs
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Written Comments to Hospital Refund Bill Workgroup on November 16, 2022

Dear Ms. Renfrew:

On behalf of the Maryland Hospital Association's (MHA) 60 hospitals and health systems, we appreciate the opportunity to help fulfill requirements under House Bill 694. The bill requires the Health Services Cost Review Commission (HSCRC), in coordination with the Comptroller's Office, Department of Human Services (DHS), and MHA, to develop a process to identify and reimburse patients who may have paid out-of-pocket for hospital services but may have been eligible for free care at the time of service.

Maryland hospitals have 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 use multiple channels to inform patients about available financial assistance, including free or reduced-cost care. Over the years, our already robust requirements around financial assistance, billing, and collections have been further strengthened. While the draft report appropriately prioritizes patient privacy, we hope the appropriate state agencies and stakeholders will continue to identify opportunities to reduce consumer cost exposure and ease barriers to access resulting from aggressive payer practices and underinsurance.

Protect Privacy, Improve Data Access

We appreciate HSCRC's acknowledgment in the report of the significant privacy concerns and operational challenges with the bill as introduced. Protecting the privacy of patients and their data is of the utmost importance for our hospitals. Even with safeguards in place, data exchange between various state agencies and hospitals increases the risk of a breach. Any sharing must be done in accordance with state and federal laws and would likely require legislation.

During the session and in the first two work group meetings, extensive deliberations on the bill 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. As we have consistently noted during session and in the work group process, a better tool to support those who need financial assistance is interoperable systems hospitals could access to determine eligibility. While the work group was charged with undertaking a retrospective review of data from five years ago, we hope they will consider mechanisms that provide hospitals with information needed to qualify individuals for free care and financial assistance moving forward.

Feedback on Proposed Options
The report considered four process options with varying data flows and sources. It should be noted that all hospitals are experiencing historic workforce shortages, with vacancies in one in every five hospital positions. Of the four, Option 1 would be the most difficult to execute for hospitals, regardless of size, due to the sheer volume of patient contacts—with most individuals receiving notice about a process they would not be eligible for. This is similar to the way hospitals already communicate about available financial assistance and payment plans. This communication starts at admissions, and there are multiple attempts to share this information for the months following discharge. The unfunded, administrative burden on hospitals that already face considerable labor challenges is not feasible. The other options narrow the field to individuals who *may* be eligible, while Option 1 requires hospitals to contact the entire patient population with an out-of-pocket hospital expense. If this option were modified, for example, with a PSA-like approach that included electronic notice to all patients—email, patient portal, and/or web notification—MHA could revisit this option with hospitals. Such an approach would likely not require legislation, and HSCRC could oversee it under existing regulatory authority.

The operational impact of the other three options varies based on hospitals' size and resources, so MHA cannot recommend a preferred approach. Regardless of the option, MHA agrees with HSCRC that certain claims contain sensitive health information. We agree with HSCRC that substance abuse data protected in Part 2 of Title 42 of the Code of Federal Regulations should be excluded from data sharing. We anticipate having to work with HSCRC and legal counsel to identify codes to exclude from data sharing.

Keep the $25 Minimum Out-of-Pocket Expense Threshold
MHA agrees with HSCRC's assertion to apply a $25 minimum to comply with financial assistance regulations in effect from 2017 through 2021. Any deviation from this policy results in retrospective policy making.

Use an Incremental Approach
MHA also supports HSCRC's proposal to assess the response rate by testing one or two years of data. HB 694 relied on a data set used by HSCRC to estimate the impact of future policy changes, not to refund patients. The resulting figures were imputed based on several assumptions. As reflected in HSCRC's comments during last year's legislative session, actual payments would likely be a fraction of the estimate HSCRC included in the original report. We believe a trigger that allows HSCRC to evaluate the impact of the process, similar to provisions in the bill as introduced, is reasonable.

Fund Administrative Costs
Given the challenges hospitals face due to inflation and labor shortages, hospitals should not incur additional costs without rate support. Reimbursing state agencies to comply with the refund law would exacerbate the once-in-a-lifetime cost and labor pressures hospitals face today due to the Covid-19 pandemic.

We encourage HSCRC to consult with stakeholders before adjusting the process. Given the complexity, not doing so may disrupt hospital practices and detrimentally harm patient care. We appreciate your time and attention and look forward to continuing this dialogue.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment