



Maryland
Hospital Association

October 12, 2021

Adam Kane
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Proposed Regulations – COMAR 10.37.10.07-1

Dear Chairman Kane:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed Rate Application and Approval Procedures regulations.

MHA appreciates the Commission's recognition that telehealth is a permanent delivery method for hospital services. Waivers and flexibilities for telehealth during the COVID-19 public health emergency helped hospitals deliver safe, effective services, while ensuring Medicare beneficiaries can access quality care when and where they need it. Telehealth also remains an increasingly vital tool for hospitals and health care professionals to reach the goals of Maryland's Total Cost of Care Model. Our members use these flexibilities to innovate, shifting care delivery in a way that will outlast the public health emergency if there is an appropriate statutory and regulatory framework.

However, MHA has several concerns about the proposed regulations:

Requirement for Provider to be "At the Hospital"

By limiting the definition of telehealth services to those delivered "by a health care provider at a hospital," the proposed regulations do not align with the Preserve Telehealth Access Act (PTAA), which was signed into law this year.

The legislation was intended to allow health care professionals and patients to safely engage in medically necessary services via telehealth, regardless of either party's location, and to be reasonably reimbursed for those services. Removing site prohibitions allowed physicians to safely see patients during nontraditional work hours. This expanded health care access, especially for behavioral specialties, where there is a documented provider shortage and increasing need. Limiting providers to hospital sites when delivering telehealth services will harm patient care and disrupt hospitals' efforts to mitigate exposure to COVID-19.

Although this language aligns with the Commission’s authority to only regulate hospital services, telehealth opens the door for hospital services to be increasingly delivered in nonhospital settings.

Hospital Costs and Telehealth Charges

On the surface, allowing only professional fee billing for a physician or other health care provider to evaluate a patient from a remote location is reasonable. However, hospitals pay direct and indirect costs to operate these services and are bound by HSCRC regulations when establishing charges to cover these costs. Therefore, we urge the Commission to acknowledge that hospitals still incur direct costs if personnel who cannot bill professional fees are involved in the visit, as well as indirect costs of patient registration, billing, system maintenance, and technology infrastructure.

MHA is concerned the proposed language prohibiting hospital charging for telehealth services distorts the underlying relationship between service costs and individual patient billing. Per Health – General § 19-219(a)(1), the Commission is charged with ensuring “[t]he aggregate rates of the facility are related reasonably to the aggregate costs of the facility.” Additionally, if hospitals cannot bill for the telehealth service, then there is no way for the hospital to track telehealth usage and assign the appropriate costs.

Without a mechanism to charge for telehealth services, hospital costs are spread to other centers. Direct hospital costs to provide telehealth services, such as nursing or other departmental staff, are likely accumulating in the clinical (CL) rate center. Indirect costs, such as registration, billing, operations, and maintaining information systems, are allocated to the CL rate center or spread throughout the hospital. Therefore, CL services billed for in-person visits, or other hospital service prices are artificially higher as rates are aligned with actual costs. During the pandemic, CL volumes decreased as hospitals moved toward virtual visits. If the telehealth costs accumulate to the CL rate center, CL rates charged for in-person visits are higher. One potential solution would be to create a new rate center that accumulates the direct and indirect telehealth costs—establishing a new rate to properly charge for these services.

Overall hospital charges are limited by global budget revenue (GBR), a cornerstone of HSCRC policy under our Maryland Model. MHA is not asking HSCRC to raise GBR limits. We are asking that HSCRC policy appropriately align hospital charges with the cost of telehealth.

We appreciate HSCRC’s proposal to establish permanent guidance on this matter. Before the Commission considers final regulations, MHA proposes HSCRC establish a work group of integral stakeholders to identify long-term, sustainable solutions for reasonable rates for hospital telehealth services. This will give HSCRC the opportunity to better understand hospital costs, the ability to connect providers outside of the hospital, and the need to align charging under our GBR model.

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Thank you for your consideration, and please do not hesitate to contact me if you have any questions.

Sincerely,



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