Minutes
Reimbursement Process Workgroup
HSCRC Monday, May 30, 2024
11:00 AM – 12:00 PM
4160 Patterson Avenue
Baltimore, MD 21215

Attendees (all virtual meeting)

HSCRC Staff:

Megan Renfrew, Claudine Williams, Andrea Strong, Chris O'Brien, William Hoff, Curtis Wills, Wayne Nelms, Paul Katz

Workgroup Members and Other Attendees::

Solomon Durgam, DHS; Bryan Thompson, WIC/MDH; Meenakshi Gajendiran, DHS; Jennifer L. Wilson, WIC/MDH; Aaron Clutter, Frederick Health; Albert Galinn, JHHS; Anita Petri, GBMC; Brandy Richmond, Comptroller; Heather Forsyth, HEAU; Kimberly Cammarata, HEAU; Diana-Lynne Hsu, MHA; Jeffrey Hill, Comptroller; Lauren Klemm, GBMC; Marceline White, Economic Action Maryland; Patrick Teta, Meritus Health; Judy Riesen, ChristianaCare; Krista Sermon, Comptroller; Sarah Stowens, ChristianaCare

I. **Welcome and Introductions:** Megan Renfrew welcomed the workgroup, reviewed the agenda, reviewed rules for collaboration and considerations for discussions – fairness/consistency, safety of vulnerable populations, and data security/privacy.

II. **Options for letter distribution:** Ms. Renfrew reviewed the current options for letter distribution:
Option 1- One letter per agency per unique eligible patient, containing all hospitals and all eligible years (2017-2021) where that patient is eligible. This yields 0-3 letters per patient, has the lowest cost, and would use State agency branding.
Option 1A: Same as Option 1 but each state agency sends letters to qualifying patients twice. This yields 0-6 letters per patient and would use State agency branding.
Option 2: One letter per patient per agency per hospital for all years (2017-2021) combined where that patient is eligible. This yields 0-many letters per patient (# of agency matches multiplied by # of hospitals), has the highest cost, and could use State agency or hospital branding (pending hospital input and agency capacity).

III. **Sample letter text:** Ms. Renfrew shared letter drafts for Options 1, 1a, and 2.

IV. **Logistics:** Given the limited timeframe remaining for the process, Ms. Renfrew noted that a decision was made to process all years at once rather than starting with one year to test the process. State agencies should start procurement processes as letters will now be sent by agencies rather than hospitals. Decisions on branding will need to be made that consider the resulting customer service burden.

V. **Discussion of letter distribution:** Diana Hsu, MHA, inquired if agencies have the capacity to merge hospitals into one letter. Ms. Renfrew noted this would need to be discussed with State

agency data management teams.

Heather Forsyth, HEAU, noted that there will likely be differences in the patient addresses between hospitals and State agencies. Ms. Renfrew agreed and offered that this would be included in a future discussion.

Ms. Hsu noted the issues due to federal and state tax restrictions, and that hospital branding might be problematic as hospitals won't know that the customer was contacted. Ms. Renfrew clarified that the issue is not just tax law. Rather, 3rd party access to data is an issue with all state agencies, not just the Comptroller.

Krista Sermon, Office of the Comptroller, noted that the hospitals couldn't comply with the data requirements and asked if the letter would be a patient's proof of eligibility. Ms. Renfrew noted that a letter generally demonstrates proof, however, there still may be eligibility steps (e.g. if a hospital had an asset test in place at the time).

Validation process: It was noted that a validation process should be included for fraud prevention, such as a reference number for the benefit of the hospitals. Ms. Forsyth noted that a reference number could also help consumers by proving they have a letter and minimizing multiple calls.

Albert Galinn, JHHS, suggested a reference number could help to differentiate and/or validate where multiple letters are received by a single patient.

Ms. Sermon noted that a claim number could help with validation if the same number is on multiple letters. There will also be calls from patients that did not receive a letter.

Mr. Galinn asked how hospitals would know what year the patient was eligible. Ms. Renfrew responded that this will be in the letter for the patient to share unless it could also be embedded in a reference number.

Further discussion is intended to determine the inclusion of a viable reference number (e.g. encounter number, account number, claim number, etc.).

VI. **Co-branding of letters:** The topic of co-branding on the letters was raised, whether this is needed, and if this would be useful to avoid customer service calls to the State agency sending the letter.

Ms. Hsu noted that co-branding would make it appear that hospitals know letter content and that patients couldn't necessarily send/scan a copy of the letter for the hospitals.

Ms. Forsyth suggested patients be directed to retain the letter to cite when calling hospitals.

VII. **Number of letters:** Ms. Renfrew noted that estimates are still being researched to indicate a maximum number of letters to be sent. There is no specific data on this population so Medicaid data has been used as a proxy, suggesting about a third of patients may visit multiple hospitals. Input from hospitals and agencies about the content of the letters has been requested, with the intention of having consistency in the structure of the letters. Alternative process flows were suggested to minimize the number of letters, however, each would violate data sharing restrictions.

Ms. Forsyth leans toward a recommendation of Option 1a but with the second letter clearly marked as a duplicate, to ensure a greater number of notices to each patient.

Marceline White, Economic Action Maryland, expressed a preference for Option 2, noting that it often takes five touches to break through to a recipient. Letters are often discarded, and one is not enough. State agency branding may get more attention. Ms. Renfrew asked if Option 1a with more than two letters could be better than Option 2. Ms. White suggested that is possible, as it would result in more letters to the patient.

Ms. Sermon suggested Option 2 (with hospital co-branding) may appear more official to patients but there may be a point of diminishing returns.

VIII. **Next steps:** Ms. Renfrew asked for comments on letter content by 6/15 and noted upcoming Data Management and Consumer Support/Comms subgroup meetings coming up, 6/4 and 6/7 respectively. Hospitals that had asset tests in place in 2017-2021 should submit these policies to HSCRC. An updated Memorandum of Understanding, Data Sharing Nondisclosure Agreement, and Scope of Work are coming soon.