Health Education and Advocacy Unit
Office of the Attorney General

FACILITY FEE RIGHT TO KNOW ACT

Senate Bill 632 | House Bill 915

.07-1 Outpatient Services — At the Hospital Determination.

A. Definition. In this regulation, "at the hospital" means a service provided in a building on the campus of a hospital in which hospital services are provided.

B. A service at the hospital is:

(1) Presumed to be an outpatient service; and

(2) Subject to rate regulation.

C. In accordance with Health-General Article, §19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to outpatient services provided at the hospital. Outpatient services associated with the federal 340B Program under the federal Public Health Service Act provided in a department of a regulated hospital that, on or before June 1, 2015, is under a merged asset hospital system, and which are physically located at another regulated hospital under the same merged asset hospital system, shall be subject to the rate-setting jurisdiction of the Commission. The Commission may begin setting rates for these services in anticipation of the hospital's obtaining provider-based status for purposes of the 340B Program.

D. A hospital that desires an exception to the presumption stated under §C of this regulation must receive a determination under the provisions of this regulation.

E. Commission Approval.

(1) A hospital may not charge a Commission-approved rate for an outpatient service without prior Commission or Commission staff approval.

(2) A hospital may not open a new outpatient service, relocate an existing outpatient service, or convert an existing outpatient service from regulated or unregulated status without a prior determination from the Commission's staff as to whether the service is being provided at the hospital. A request for determination shall be made in writing at least 60 days before the contemplated action.

F. Upon request for an exception under §D of this regulation, the Commission's staff shall:

(1) Review the information presented;

(2) Consult with appropriate parties;

(3) Visit the site of the service as it considers necessary; and

(4) Notify the hospital of its determination as soon as practicable.

G. In deciding whether an outpatient service is at the hospital, the Commission staff may consider, among other things, the following criteria:

(1) Location of the entrances;

(2) Location and signage of parking;

(3) Location and language of signage at entrances, within buildings, on the campus, and in parking areas effectively alerting the public that a given building or service is either at the hospital or not at the hospital;

(4) Location of registration, changing, and waiting areas;

(5) Whether billing reflects clearly that the service is rate regulated or not rate regulated;

(6) Whether any physical connection from an unregulated facility to the hospital, such as tunnels, hallways, covered walkways, elevators, or connecting bridges, will be restricted to hospital staff and physician use in order to ensure that patients and visitors do not have access to the unregulated facility from the hospital;

(7) Whether there is any duplication of an unregulated service within the hospital in order to avoid inappropriate patient steering;

(8) Whether there is any inappropriate mixing of regulated and unregulated services in the same building, which would tend to have the effect of confusing patients about the regulated or nonregulated status of a given service being provided; and

(9) Whether any Medicare Part B physician's service being provided in an unregulated building also includes components of a Medicare Part A hospital service that would be reasonably expected by a patient to fall under Commission rate-setting jurisdiction.

H. Based on consideration of the criteria stated in §G of this regulation, the Commission's staff shall make its determination on the request made under §E of this regulation.

I. A hospital that fails to obtain or violates a staff determination on the hospital status of a given service may be subject to fines for inaccurate reporting under COMAR 10.37.01.03R and paybacks for inappropriate charges made during the time a staff determination on an outpatient service was not obtained or adhered to.

J. A request for a determination under this regulation is not a contested case under the Administrative Procedure Act.

.07-2 Outpatient Services — Freestanding Medical Facility.

A. Definition. In this regulation, "freestanding medical facility" means a freestanding medical facility licensed under Health-General Article, Title 19, Subtitle 3A, Annotated Code of Maryland.

B. The following outpatient services provided at a freestanding medical facility are considered hospital services under Health-General Article, §19-201, Annotated Code of Maryland:

(1) Emergency Services;

(2) Observation Services; and

(3) Associated Ancillary Services, such as laboratory, radiology, imaging, EKG, and Medical/Surgical Supplies and Drugs.

C. In accordance with Health-General Article, §19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to those outpatient services provided at a freestanding medical facility, as designated by the Commission.

D. A freestanding medical facility or a proposed freestanding medical facility that desires to provide a service not designated in §B of this regulation (an undesignated service) must receive a determination under the provisions of this regulation.

E. Commission Approval.

(1) A freestanding medical facility may not charge a Commission-approved rate for an undesignated service without prior Commission staff approval.

(2) A freestanding medical facility may not open a new outpatient service, relocate an existing outpatient service, or convert an existing outpatient service from regulated or unregulated status without a prior determination from the Commission's staff as to whether the service constitutes a hospital service subject to Commission rate regulation. A request for determination shall be made in writing at least 60 days before the contemplated action.

F. Upon request for a determination, the Commission's staff shall:

(1) Review the information presented;

(2) Consult with appropriate parties;

(3) Visit the site of the service as it considers necessary; and

(4) Notify the freestanding medical facility of its determination as soon as practicable.

G. In deciding whether the service constitutes a hospital service subject to Commission rate regulation, Commission staff shall consider, among other things, the following criteria:

(1) Cost of the service;

(2) In consultation with Maryland Health Care Commission (MHCC) staff, access to and need for the service in the community;

(3) Feasibility of providing the outpatient service in the community on an unregulated basis; and

(4) Impact of the service on the All-Payer Model including, but not limited to, the Total Cost of Care limitations as prescribed in the All-Payer Model Agreement with the Center for Medicare and Medicaid Innovation.

H. Based on the consideration of the criteria stated in §G of this regulation, the Commission staff shall make its determination on the request made under §E of this regulation within a reasonable period of time, taking into account, among other things, whether either a Certificate of Need application to establish a freestanding medical facility or a request for exemption from Certificate of Need to convert a licensed general hospital to a freestanding medical facility is pending before the MHCC and, if so, the time frame for staff to comment to MHCC on the financial feasibility of the proposed project.

I. A freestanding medical facility that fails to obtain, or violates, a staff determination on the regulated status of a given service may be subject to fines for inaccurate reporting under COMAR 10.37.01.03R and paybacks for inappropriate charges made during the time a staff determination on an outpatient service was not obtained or adhered to.

.08 Content.

Each rate application shall include a list of services for which new rates are being requested, a list of the present and requested rates, and shall be based on the currently filed or required rate review system.

.09 Method of Filing.

The application may be filed by private messenger at the Offices of the Commission, or may be filed by registered mail, return receipt requested, at the following address:

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

.10 Docketing and Receipt.

A. Docketing.

(1) When a valid rate application is received, as per the above regulations, it shall be entered on the Commission docket and a file opened.

(2) Each rate application shall be given an annual docket number and a consecutive page number in the docket.

(3) Each rate application shall be given a consecutive file number.

(4) A regular rate application file number shall be noted "R".

(5) The file number of an order authorizing Commission investigation and review of established rates shall be noted "C".

(6) A temporary rate application file number shall be noted "I".

(7) An alternative method of rate determination application file number shall be noted "A".

(8) A rate application file number by a new hospital or a hospital with expanded facilities or new revenue centers shall be noted "N".

(9) The date of receipt of the rate application shall be noted on the docket and on the file.

Maryland Register

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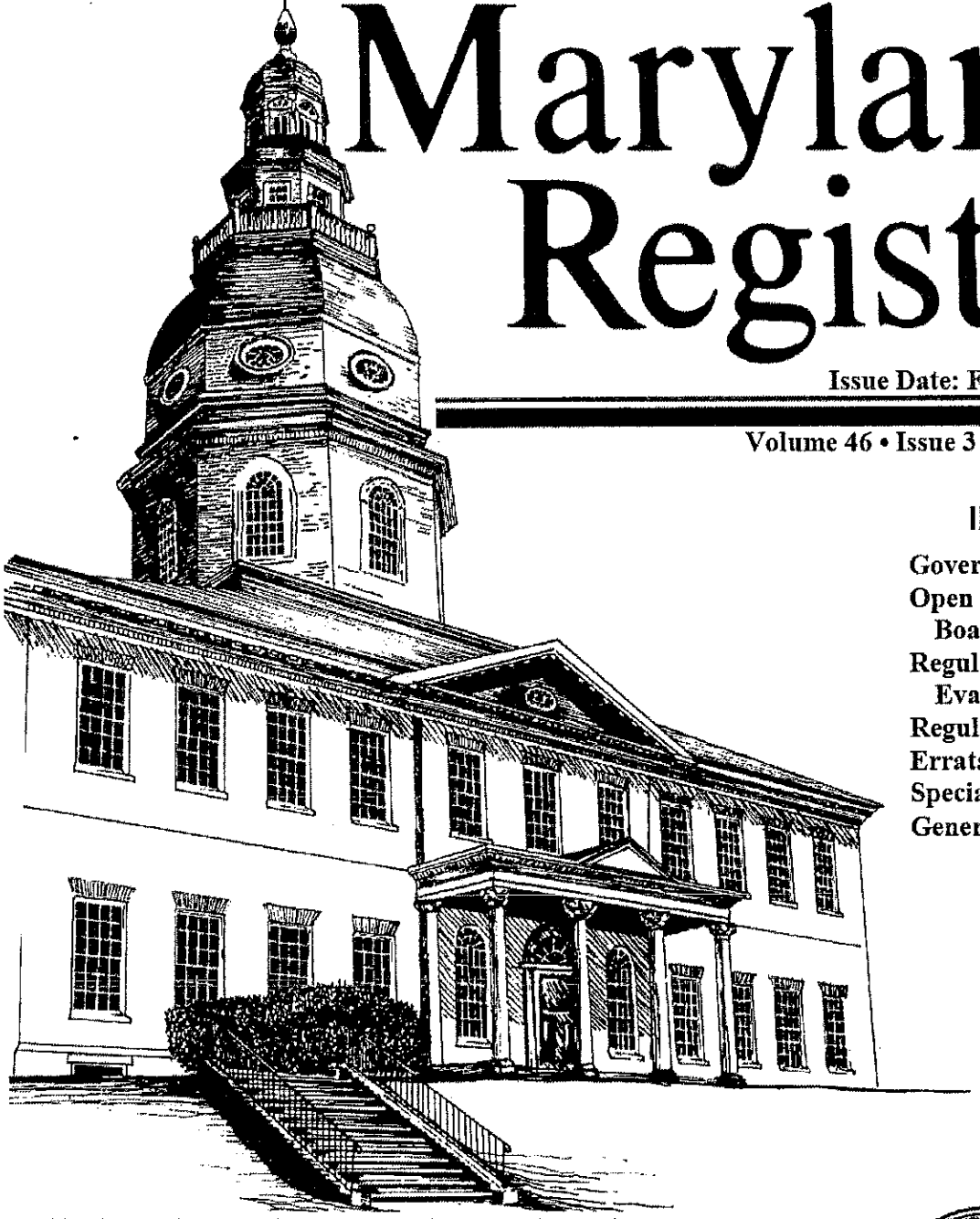


IN THIS ISSUE

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, this issue contains all previously unpublished documents required to be published, and filed on or before January 14, 2019, 5 p.m.

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, I hereby certify that this issue contains all documents required to be codified as of January 14, 2019.

Gail S. Klakring
Administrator, Division of State Documents
Office of the Secretary of State

Subtitle 33 BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

10.33.01 Nursing Home Administrators

Authority: General Provisions Article, §4-333; Health Occupations Article, §§1-212, 1-606, and 9-101—9-502; State Government Article, §10-226; Annotated Code of Maryland

Notice of Proposed Action

[19-049-P]

The Secretary of Health proposes to amend Regulations .13 and .16 under **COMAR 10.33.01 Nursing Home Administrators**. This action was considered by the Board of Examiners of Nursing Home Administrators at public meetings held on September 12, 2018, and November 14, 2018, notice of which was given by publication on the Board's website at https://health.maryland.gov/bonha/Pages/Index.aspx pursuant to General Provisions Article, §3–302(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to require that a preceptor, who is the administrator of record of the facility in which training is to take place, have a minimum of 30 days in that facility as its administrator. Additionally, a clarification is being made regarding complaints and the authority of the disciplinary subcommittee.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Jake Whitaker, Acting Director, Office of Regulation and Policy Coordination, Maryland Department of Health, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to mdh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through March 4, 2019. A public hearing has not been scheduled.

.13 Administrator-in-Training.

A.—E. (text unchanged)

F. Application Requirements.

(1)—(7) (text unchanged)

(8) The preceptor may or may not be the administrator of record of the facility in which the training is to take place, but the preceptor may not be the administrator of record of a facility other than the one designated for training. *If the preceptor is the administrator of record of the facility where the training is to take place, the preceptor shall have had a minimum of 30 days of oversight in the facility in which the training is to take place immediately prior to beginning the AIT program.*

(9)—(11) (text unchanged)

G.—L. (text unchanged)

.16 Complaints and Hearing Procedures.

A.—D. (text unchanged)

E. Prosecution of [Complaint] *Complaints*.

(1) For each complaint, after reviewing the complaint, [and] any investigative material, [the Board, through its] *and the* disciplinary [subcommittee] *subcommittee's recommendation, the Board* shall:

(a)—(c) (text unchanged)

(2)—(3) (text unchanged)

ROBERT R. NEALL
Secretary of Health

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-214.1 and 19.214.3, Annotated Code of Maryland

Notice of Proposed Action

[19-027-P]

The Health Services Cost Review Commission proposes to amend Regulation .26 under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 14, 2018, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about March 5, 2019.

Statement of Purpose

The purpose of this action is to require hospitals to better inform patients of facility fees and their right to request and receive a written estimate of the total charges for the nonemergency hospital services, procedures, and supplies that reasonably are expected to be incurred and billed to the patient by the hospital.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The proposed action is aimed at better informing hospital patients of what to expect when they are subsequently billed for services provided at hospitals. For example, many if not most patients are unaware of their right to receive a written estimate of what their total charges will be for nonemergency hospital services expected to be provided at the hospital. The proposed action results in better informed patients.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	NONE	
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	(+)	Significant

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

F. This assumption is based on the belief that when patients are better informed of the costs of hospital care before those costs are incurred, it is more likely that they will make prudent health care delivery decisions.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through March 4, 2019. A public hearing has not been scheduled.

.26 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies.

A. Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a)—(c) (text unchanged)

(d) Provides contact information for the Maryland Medical Assistance Program; [and]

(e) Includes a statement that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately[.]*;*

(f) Informs patients that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee", for their use of hospital facilities, clinics, supplies and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(g) Informs patients of their right to request and receive a written estimate of the total charges for the hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital.

(2) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(a) Before the patient receives scheduled medical services;

[(a)] *(b)*—[(c)] *(d)* (text unchanged)

(3)—(4) (text unchanged)

A-1.—C. (text unchanged)

NELSON SABATINI
Chairman
Health Services Cost Review Commission

Subtitle 43 BOARD OF CHIROPRACTIC EXAMINERS

10.43.05 Chiropractic Externship Program

Authority: Health Occupations Article, §§3-205 and 3-301, Annotated Code of Maryland

Notice of Proposed Action

[19-045-P]

The Secretary of Health proposes to amend Regulations .01—.04 under **COMAR 10.43.05 Chiropractic Externship Program.** This action was considered by the Board of Chiropractic Examiners at a public meeting held on October 11, 2018, notice of which was given by publication on the Board's website at https://health.maryland.gov/chiropractic/Pages/index.aspx pursuant to General Provisions Article, §3–302(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to update and reflect changes in the chiropractic profession, add preceptorship language, and clarify eligibility requirements established in Ch. 658, Acts of 2018.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Jake Whitaker, Acting Director, Office of Regulation and Policy Coordination, Maryland Department of Health, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to mdh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through March 4, 2019. A public hearing has not been scheduled.

.01 Scope.

These regulations apply to all [chiropractic]*:*

A. Chiropractic externs, *chiropractic extern applicants,* and licensed chiropractors who are extension faculty members of a chiropractic college accredited by the Council on Chiropractic Education or its successor[.]*; and*

B. Licensed chiropractors approved by the Board to provide an externship.

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) "Accredited [college] *Board-approved educational institution*" means a chiropractic school [or], college, *or university* accredited by the Council on Chiropractic Education or its successor.

(2) "Approved program" means a program that has been approved by the Board [of Chiropractic Examiners] and the Council on Chiropractic Education or its successor.

(3) (text unchanged)

(4) "Chiropractic extern program" means [a]*:*

(a) A 2-semester clinical program:

[(a)] *(i)* In which *a* chiropractic [externs participate] *student, that has completed all requirements to graduate, participates* under

party to the proceeding is entitled, on timely request, to an opportunity to show that the Commission should not take official notice of specific facts and matters or that the fact or matter to be officially noticed is inapplicable to the proceeding or is incorrect or misunderstood by the Commission.

I. In reviewing a hospital's rate structure, the Commission may consider or take official notice of any public document, including, but not limited to, any filing made with the Maryland Health Resources Planning Commission relative to a Certificate of Need application including all projections of volumes, revenues, rates, and feasibility studies, as well as any public document concerning the financing of a project approved pursuant to a Certificate of Need.

.26 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies.

A. Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a) Describes the hospital's financial assistance policy;

(b) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(c) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i) The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost, medically necessary care due to a financial hardship;

(iii) How to apply for free and reduced-cost care; and

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;

(d) Provides contact information for the Maryland Medical Assistance Program; and

(e) Includes a statement that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately.

(2) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(a) Before discharge;

(b) With the hospital bill; and

(c) On request.

(3) The hospital bill shall include a reference to the information sheet.

(4) The Commission shall:

(a) Establish uniform requirements for the information sheet; and

(b) Review each hospital's implementation of and compliance with the requirements of this section.

A-1. Hospital Credit and Collection Policies.

(1) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients.

(2) The policy shall:

(a) Prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained;

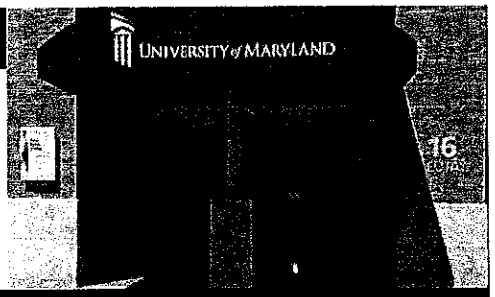
(b) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(c) Describe the hospital's procedures for collecting any debt;

(d) Describe the circumstances in which the hospital will seek a judgment against a patient;

(e) Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care on the date of service, in accordance §A-1(3) of this regulation;

HOW TO FIND US!



UNIVERSITY of MARYLAND MEDICAL CENTER

Directions to the UMMC Frenkil Building
16 S. Eutaw Street • Baltimore, MD 21201

From the North or South
- Follow I-95 to Exit #53/I-395 North to Martin Luther King Blvd.
- Turn right onto Pratt St.
- Go four blocks and turn left onto Eutaw St.
- Go one block to Lombard St.
  - **To valet park–** turn left onto Lombard St. Take next right onto Paca St. Turn left onto Redwood St; or
  - **For the Redwood Garage*–** cross Lombard St. and continue for one-half block. Turn right into the garage.

From the West
- Take I-70 East to I-695 South (Glen Burnie).
- Follow I-695 to I-95 North.
- Take Exit #53/I-395 North to Martin Luther King Blvd.
- Turn right onto Pratt St.
- Go four blocks and turn left onto Eutaw St.
- Go one block to Lombard St.
  - **To valet park–** turn left onto Lombard St. Take next right onto Paca St. Turn left onto Redwood St; or
  - **For the Redwood Garage*–** cross Lombard St. and continue for one-half block. Turn right into the garage.

From I-83 South
- Follow I-83 (Jones Falls Expy.) to the end.
- Go two traffic lights and turn right onto Lombard St.
  - **To valet park–** continue on Lombard St., to S Paca St. and turn right. Turn left onto Redwood St; or
  - **For the Redwood Garage*–** continue on Lombard St. to S. Eutaw St. Turn right onto Eutaw and continue for one-half block. Turn right into the garage.

From Eastern Shore/Bay Bridge
- Take US-50 West to US-301.
- Take Exit #21 to I-97 North.
- Take Exit #17A/I-695/Baltimore/Towson.
- Take Exit #7B/MD-295 N/Balt-Wash Pkwy. North/Baltimore I-295 exit and follow the directions from Washington D.C. or BWI Airport.

From Washington D.C. or BWI Airport
- Follow I-295 North to Baltimore.
- Take Exit #4A/I-95 N/I-695/Baltimore.
- Take Exit #53/I-395 North and follow that to the I-395 exit to Martin Luther King Blvd.
- Turn right onto Pratt St.
  - **To valet park–** turn left onto Paca St. Turn right onto Redwood St; or
  - **For the Redwood Garage*–** turn left onto Eutaw St. and continue for one-half block. Turn right into the garage.

Public Transportation
BUS: MTA buses **19** and **27** have stops nearby.

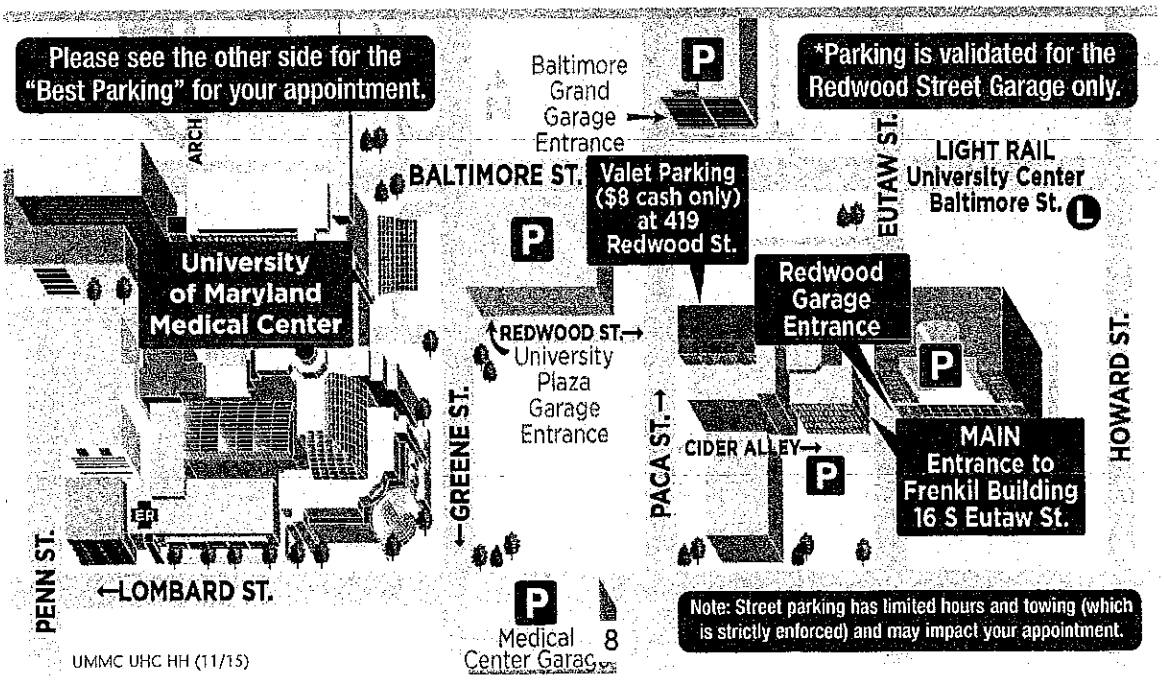
CHARM CITY CIRCULATOR: Free shuttle service that runs every 10 minutes. Patients and visitors can ride shuttles along the Orange Route and take stops **#216** or **#217** for the Medical Center.

SUBWAY: **Lexington Market Station,** Eutaw and Lexington Streets (4 blocks).

Charles Center Station, Baltimore at Charles St. (5 blocks).

LIGHT RAIL: The Central Light Rail Line stops at the University Center/Baltimore Street Station at the corner of Howard Street and Baltimore Street.

Valet Parking is $8 (cash only).



SUPPLEMENTAL SCHEDULE 7

MedStar Good Samaritan Hospital

For The Fiscal Year Ended June 30, 2015

Name of Outpatient Service	Description of Services Provided	Physical Location/Address	Regulated/ Unregulated
Hospital Owned Outpatient Services Regardless of Location			
EKG	EKG's	Main Hospital - Ground Floor	Regulated
Respiratory	Respiratory Services	Main Hospital - Ground Floor	Regulated
Renal	Renal Dialysis	Main Hospital - Ground Floor	Unregulated
Laboratory	Lab Services	Main Hospital - Ground Floor	Regulated (except blood donor center)
ASU	OP Surgery	Main Hospital - 1st Floor	Regulated
Endoscopy	Endo procedures	Main Hospital - 1st Floor	Regulated
Radiology	Diagnostic Xray, Ultrasound, Interventional Procedures, etc	O'Neill Building - 1st Floor	Regulated
Nephrology	Renal Clinics	Main Hospital - 3rd Floor	Unregulated
Short Stay Unit	Observation Services	Main Hospital - 3rd Floor	Regulated
Cardiac Cath Lab	Cardiac Cath's	Main Hospital - 3rd Floor	Regulated
Sleep Center	Sleep Studies	Main Hospital - 4th Floor	Regulated
Nuclear Medicine	Nuclear Diagnostic Services	Main Hospital - 5th Floor	Regulated
Vascular Lab	Vascular Diagnostics	Main Hospital - 5th Floor	Regulated
EEG	EEG Studies	Main Hospital - 5th Floor	Regulated
Johns Hopkins Orthopedic Services	Hospital Owned Physician Practice	Smyth Building - Ground Floor	Unregulated
Johns Hopkins Orthopedic and spine sur	Hospital Owned Physician Practice	Smyth Building - 2nd Floor	Unregulated
Wound Healing Center	Wound/Hyperbaric Clinics	Main Hospital - 2nd Floor	Regulated
Radiology	Diagnostic Xray	Smyth Building - Ground Floor	Regulated
Center for Primary Care	Primary Care Clinic	RMB - 5th floor	Regulated
Radiology	MRI/Xray/Mammo Services	RMB - Ground Floor	Regulated
Good Samaritan Cancer Center	Cancer Services (clinics/infusions)	RMB - 1st Floor	Regulated
Outpatient Pharmacy	Retail Pharmacy	Main Hospital - 1st Floor	Unregulated
Neuropsychiatry Institute at Good Samar	Outpatient Psych Services	RMB - 4th Floor	Regulated
Emergency Department	Emergency Services	O'Neill Building - 1st Floor	Regulated
Good Health Center	Cardiac Rehab, Community Services, Infusion Services, etc.	O'Neill Building - 2nd Floor	Regulated Clinic Services, Unregulated Community Services (screenings/fitness cent
Outpatient Rehab	Outpatient PT, OT and ST	O'Neill Building - 2nd Floor	Regulated
Michael A Jacobs M.D. and Derek R. Pa	Hospital Owned Physician Practice	RMB - 4th Floor	Unregulated
Department of Medicine – Dr. Frank	Hospital Owned Physician Practice	RMB - 5th Floor	Unregulated
Good Samaritan Surgery Center	Hospital Owned Physician Practice	Smyth Building - 3rd Floor	Unregulated
Good Samaritan Vascular Surgery	Hospital Owned Physician Practice	Smyth Building - 3rd Floor	Unregulated
Center for Successful Aging	OP Geriatric Clinic	RMB - 4th Floor	Regulated
Taylor Medical Group	Hospital Owned Physician Practice (Neurology)	22 West Road, Suite 10 Towson, Maryland 21	Unregulated
Outpatient Services Not Owned by the Hospital - Located in Principal Hospital Bldgs or In Other Bldgs in Which Regulated Services are Provided			
MPP Metropolitan Medical Cardiology	Private Physician Cardiology Clinics	RMB - 2nd Floor	Unregulated
Metropolitan Medical	Private Physician Multi-specialty Clinics	RMB - 3rd Floor	Unregulated
Podiatry Associates P.A	Private Physician Clinics	RMB - 4th Floor	Unregulated
Joyce Lammlein M.D.	Private Physician Clinics	RMB - 4th Floor	Unregulated
Central MD Cardiology	Private Physician Clinics	RMB - 4th Floor	Unregulated
Dr. Karas Thoracic and Vascular Sugary	Private Physician Clinics	RMB - 4th Floor	Unregulated
Johns Hopkins Clinical Practice	Private Physician Clinics	RMB - 5th Floor	Unregulated
Rheumatology Osteoporosis and Researc	Private Physician Clinics	RMB - 5th Floor	Unregulated
RadAmerica	Radiation Therapy	RMB - Ground Floor	Regulated
Neurosurgery	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated
General and Endocrine Surgery / Head a	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated
Towson Ear Nose and Throat	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated

Institute for Life Enrichment	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated
General Endocrine Surgery	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated
Head and Neck Surgery	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated
General and Minimally Invasive Surgery	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated
Nascott Prosthetics and Orthotics	Private Physician Clinics	Smyth Building - 1st Floor	Unregulated
Rheumatology	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Infectious Diseases	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Thoracic Surgery	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Center for Osteonecrosis Research	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Clinical Research Group National Osteo	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Metropolitan Medical Association	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
MedStar Physician Partners Dermatolog	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Sollay Pain Relief Center	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Physicians Weight Loss Center	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Gastroenterology – Lawrence Mills, Jr. M	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Good Samaritan Dental and Surgical	Private Physician Clinics	Smyth Building - 2nd Floor	Unregulated
Institute for Life Enrichment	Private Physician Clinics	Smyth Building - 3rd Floor	Unregulated
Mary L. Tavor-Ennis P.H.D. and Associ	Private Physician Clinics	Smyth Building - 3rd Floor	Unregulated
Greater Baltimore Vascular Surgery at G	Private Physician Clinics	Smyth Building - 3rd Floor	Unregulated
Medstar Home Nursing	Private Physician Clinics	Smyth Building - 3rd Floor	Unregulated
Center for Women's Health	Private Physician Clinics	Smyth Building - 3rd Floor	Unregulated
Chesapeake Urology	Private Physician Clinics	Smyth Building - 3rd Floor	Unregulated
I. James Park, MD, PA – Gynecology	Private Physician Clinics	Smyth Building - 4th Floor	Unregulated
Pediatrics – Chan Aung, M.D. and Stella	Private Physician Clinics	Smyth Building - 4th Floor	Unregulated
Johns Hopkins University Physical Medi	Private Physician Clinics	Smyth Building - 4th Floor	Unregulated
JH Physical Medicine and Rehab	Private Physician Clinics	Smyth Building - 4th Floor	Unregulated
Mobile PET	Mobile PET Services	RMB - 1st Floor	Unregulated

BRIAN E. FROSH
Attorney General

CAROLYN QUATTROCKI
Chief Deputy Attorney General

ELIZABETH HARRIS
Deputy Attorney General

STANLEY LUSTMAN
Assistant Attorney General

LESLIE C. SCHULMAN
Assistant Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

TELECOPIER NO.
410-358-6217

WRITER'S DIRECT DIAL NO.
410-764-2575

June 19, 2017

Mr. Mike Wood, Senior Director
Reimbursement & Revenue Advisory Services
University of Maryland Medical System
250 W. Pratt Street
Baltimore, MD 21201-1595

RE: Relocation of Organ Transplant Related Physician Practices to Unregulated Space in Frenkil

Dear Mike:

This letter is written on behalf of the staff of the Health Services Cost Review Commission ("HSCRC"), and responds to the regulatory issues raised in your letter of May 26, 2017 and those discussed concerning the relocation of pre and post-Organ Transplant related physician offices to unregulated space in the Frenkil Building on the University of Maryland Medical Center ("UMMC" or "Hospital") campus. For the purpose of providing more efficient and effectives services to its transplant patients, UMMC is seeking approval to consolidate these physician practices into one location on the 1st floor of Fenkil Building. Specifically, you have requested a staff determination confirming that the HSCRC would not confer rate-setting jurisdiction over these Part B services that are targeted to begin seeing patients in September 1, 2017. For the reasons discussed below, staff concurs with your plans.

The Frenkil Building, located at 16 S. Eutaw Street, is a five story building that houses regulated Clinics and administrative/ business space. Regulated specialty clinics, including a post- kidney transplant Nephrology clinic are located on the 2nd floor. UMMC's regulated Neurology Ambulatory Center occupies the 3rd floor. UMMC's Otolaryngology Outpatient Center is situated on the 4th floor. The 5th floor houses UMMC's regulated Outpatient Therapy Clinic, as well as UMMC business offices. The first floor of Frenkil is presently unoccupied and UMMC management is proposing to utilize the space to house the two private pre and post-transplant related physician practices whose offices are currently located at 29 S. Greene Street and 419 Redwood Street. Additionally, the new office suite will be clearly branded as private physician offices, not as UMMC, and will be named the "Physician Offices of the University of Maryland Transplant Center." All rendered services will be billed by the physicians on a Medicare form 1500 as a Part B service.

Based on consideration of the criteria of *COMAR 10.37.10.07-1*, as well as your representations regarding signage, billing, no duplication of services and the nature of the privatized services at issue, Staff has concluded from a rate setting perspective that the proposed private Part B services to be provided within the organ transplant private physician office suite would not be considered a hospital service. This determination is conditioned on the Hospital's pledge to notify staff in writing, at least 60 days before you contemplate changing the configuration of outpatient services which may affect staff's determination, in either the Hospital or other facilities on the University of Maryland Center's campus. Failure to obtain prior staff approval, or a violation of this determination, may subject the Hospital to fines for inaccurate reporting under COMAR 10.37.01.03R and paybacks for inappropriate charges made during the time a staff determination on an outpatient service was not obtained. Additionally, at least 60 days prior to operationalizing these Part B services, the Hospital will notify staff of the intended name of the primary care office and of the proposed signage. Lastly, a request for determination does not satisfy the separate requirement for the Hospital under its Global Revenue Budget Agreement (GBR) to notify the HSCRC of any changes in ownership and control and related service relocations. (See, GBR Agreement, Section V.B.3.- "Changes in Ownership and Control and Related Service Relocation")

If you have any further questions, I would be pleased to discuss them with you.

Sincerely,

Leslie C. Schulman
Assistant Attorney General

cc: Dennis Phelps, Assoc. Dir. Audit & Compliance

DOUGLAS F. GANSLER
Attorney General

KATHERINE WINFREE
Chief Deputy Attorney General

JOHN B. HOWARD, JR.
Deputy Attorney General

STANLEY LUSTMAN

LESLIE C. SCHULMAN
Assistant Attorneys General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

TELECOPIER NO.
410-358-6217

WRITER'S DIRECT DIAL NO.
410-764-2575

April 17, 2013

Kathleen Ring
Director, Regulatory Reporting and Reimbursement
LifeBridge Health- Sinai Hospital of Baltimore
2401 West Belvedere Avenue
Baltimore, Maryland 21215-5271

Re: **Krieger Eye Institute Clinics at Sinai- Determination**

Dear Kathleen:

This letter is written on behalf of the staff of Health Services Cost Review ("HSCRC"), and responds to the regulatory issues raised in your letter of March 11, 2013, and those discussed with us concerning the expansion of Krieger Eye Institute services situated in the Morton Mower Building ("Mower MOB") on the Sinai Hospital campus ("Sinai," or the "Hospital"). You have requested a formal determination and staff approval to convert the private faculty practices of the Krieger Eye Institute- Ophthalmology ("KEI-O"), to a permanent rate regulated clinic status. These ophthalmology specialty services would be merged with the hospital existing regulated ophthalmology resident's clinic ("Krieger Eye Institute-Rosenthal Clinic," or "KEI-Rosenthal") and the regulated Krieger Eye Institute Retina Center ("KEI-Retina"). Both KEI-Rosenthal and KEI-O were subject to a May 26, 1995 HSCRC Determination and a September 22, 1995 Sinai Hospital pledge to comply with the Commission's "At-the Hospital" rules.[1] For the reasons discussed, staff concurs with Sinai's plans to regulate all ophthalmologic services in the Mower MOB.

The Morton Mower Building (formerly known in 1995 as the Weinberg Building) is a six story regulated hospital medical office building that bears signage with the Sinai Hospital trade

[1] It should be noted that the KEI-Retina Center did not exist in 1995. Hospital representatives have now disclosed that the Hospital opened a rate regulated Retina Clinic in October of 2010, without obtaining prior Commission approval. The clinic is located in Suite 502, in close proximity to the regulated KEI-Rosenthal Clinic, and does not bear signage indicating that it is a Clinic. The signage for KEI-Retina currently reads: "Retina Center Krieger Eye Institute" with the Hospital's trade name not prominently displayed.

name. With exception to Suite 505 on the 5th floor that houses the hospital's rate regulated ophthalmology resident clinic for emergent care and Suite 502 that houses the hospital's regulated retina specialty clinic, the balance of the building is predominately occupied by private physician offices, an independent pharmacy and optical shop. Based on information disclosed to us by hospital management, both in 1995 and at the present time, the 6th floor has exclusively been occupied by the private faculty practices of the KEI-O. These faculty members also oversee the residents practicing at the KEI-Rosenthal Clinic as part of the ACGME resident program.

Due to an increase in volume growth and an increase in utilization of ophthalmology services, the management of Sinai believes that the space on the 6th floor should be operated as a traditional clinic versus private physician practice. Thus, for purposes of making the current space for these services less confusing to the patients, you have decided to convert these physician practices to hospital rate regulated services. It is anticipated that over the next month payers and patients will be notified of the changes to billing and charges associated with the change in regulatory status. Patients will receive two separate invoices: a hospital bill for the facility fee charges and a physician bill for the Part B professional services rendered.

As part of Sinai's request to convert these practices to regulated clinics, you have informed staff that the management team of Sinai will implement the following changes in operations by July 1, 2013:

- Use hospital billing forms on Sinai's letterhead
- Change all posted signage with the Hospital's name prominent and identifying the service as a Clinic
- Notify all current patients, payors of the change in regulatory status and billing
- Expand Sinai' s financial assistance policy to include this group of patients
- Register all ophthalmology patients as hospital outpatients

Based on consideration of the criteria under the provisions of COMAR 10.37.10.07-1, as well as your representations, staff has concluded from a rate setting perspective it would be appropriate for the HSCRC to permanently regulate the rates at each of Sinai Hospital's Krieger Eye Institute Clinics (Rosenthal, Retina, and Ophthalmology) situated in the Mower MOB . This determination is conditioned on the Hospital's pledge to notify staff in writing, within 60 days of any changes in service delivery at your facilities which may potentially impact staff's determination. Failure to obtain staff approval, or a violation of this determination, may subject the Hospital to fines for

inaccurate reporting under *COMAR 10.37.01.03N* and paybacks for inappropriate charges made during the time a staff determination on an outpatient service was not obtained or adhered to.

I trust the preceding is responsive to your request. If I can be of any further assistance to you, please do not hesitate to call at your convenience.

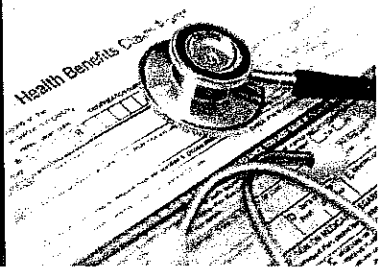
Sincerely,

Leslie C. Schulman
Assistant Attorney General

cc: Dennis Phelps, Assoc. Dir- Audit & Compliance
David Krajewski, CFO

UNDERSTANDING YOUR

MEDICAL BILL



TYPES OF BILLS YOU MAY RECEIVE

Patients treated in an outpatient setting (for example, a clinic, emergency room, or surgery) or admitted to the hospital may receive multiple bills. You may have to pay a co-pay, deductible and/or co-insurance for the physician and hospital services.

For scheduling reasons, some tests or procedures may be performed at a later date and may be billed separately. The various types of bills you may receive are:

PHYSICIAN BILL(S)

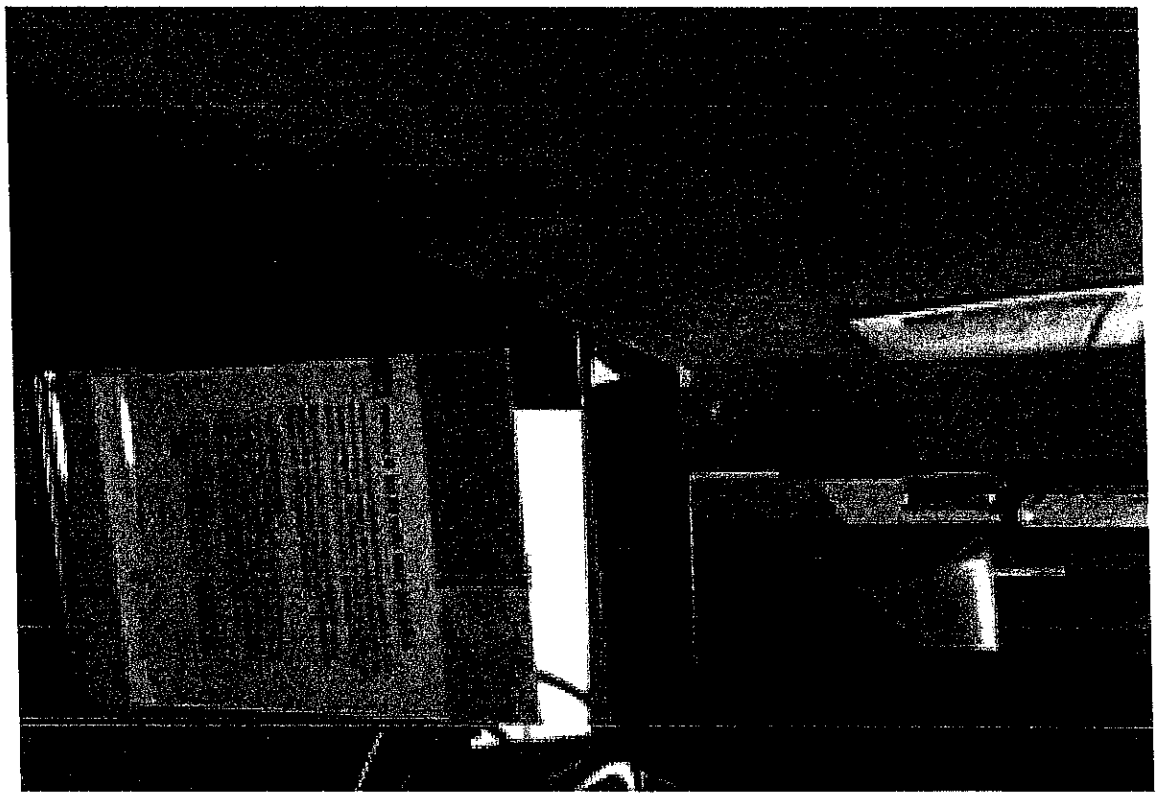
The University of Maryland Faculty Physicians, Inc., will bill physician fees. The physician bill will include the cost of medical or surgical care as well as costs involving review and interpretation of your diagnostic tests. For example, the cost for the radiologist who reads your X-ray.

OUTPATIENT BILL

The hospital outpatient bill includes charges for the use of the hospital facility and any tests or procedures you undergo.

PATIENT FINANCIAL SERVICES
22 S. Greene Street, Baltimore, MD 21201-1595
410-821-4140 | www.umm.edu

UNIVERSITY of MARYLAND MEDICAL CENTER



LIFEBRIDGE
HEALTH

The Krieger Eye Institute

May 10, 2018

Kimberly S. Cammarata
Office of the Attorney General
200 St. Paul Place
Baltimore, MD 21202

RE:

Dear Ms. Cammarata:

Per your recent letter indicating that we did not respond to the question about what, if any, oral notice was provided to Mr. that he would be billed a facility fee.

Our representatives currently do not verbally tell the patients when they schedule an appointment that there will be a facility fee charged, however when they present to the office, they are asked to sign a patient billing notice that indicates that there will be two separate bills, one for the facility and one for the physician.

At the time of this service, the call center would refer the patients to option 3 on the phone tree that directed the patients to our billing office. There they would be able to discuss the associated charges for each location.

There is no script used by the call center representative.

If I can be of further assistance to you, please let me know.

Sincerely yours,

Rose M Herring

Rose M Herring

LIFEBRIDGE
HEALTH
The Krieger Eye Institute

Weinberg Place	Hanover	OMS	Green MD, Laura K.
Northwest SMOB	Quarry	Retina Center-RECL	
Westminster	York	Weinberg 5th Floor – EYCL	
Glen Burnie	Sinai-6EYE	Retina Center - Northwest	

Billing Notice To Our Patients

The Krieger Eye Institute is an outpatient department of LifeBridge Health. Accordingly, you will receive two bills for your appointments in the office. You will receive a physician services bill from the doctor and an outpatient clinic bill from LifeBridge Health. Together, the two bills will represent charges incurred during your visit to the center. We are providing this notice to help avoid confusion when you receive two separate bills. There will be charges for facility fees even in the global period after an operative procedure.

Depending on your insurance coverage, you may be responsible for some or all of the entire bill. All charges are billed to the insurance company to determine the amount of patient responsibility. If in doubt, please contact your insurance carrier to determine the co-pay, deductible and or coinsurance amounts.

Thank you,

Patient name printed _____ Date of birth _____

Patient signature _____ Date 10/05/2017 08:40

RECEIVED
ST. MARY'S COUNTY GENERAL
OCT 6 11:45

UNIVERSITY of MARYLAND MEDICAL CENTER

Dear

Thank you for choosing the University of Maryland Medical Center. We take pride in providing the highest quality patient care. This letter contains important information about your appointment. Directions and maps are provided for your convenience. You may also find answers by visiting us online at umm.edu.

Convenient • Secure • Free

Visit **myportfolio.umm.edu** and use the code from your provider to register and view your health information.

IMPORTANT – To Avoid Delays at Check-in...

PLEASE BRING THE FOLLOWING:

- **Your picture ID or driver's license.**
- **All insurance cards.**
- **If applicable, your HMO/MCO/POS referral form from your Primary Care Physician. The referral should authorize your office visit, procedures, and lab work.**
- **Payment for any required co-payments and deductibles at the time of your visit as required by your insurance.**
- **Complete name, address, phone number, and fax number for your referring physician.**
- **List of current medications and allergies.**
- **Copies of any medical notes, lab results, biopsy or pathology slides, X-ray/testing images (CDs or film), etc.**

We reserve the right to request you reschedule:

- **If you are late for your appointment.**

Medical Record Number: 4101237

UMMC UHC HH (08/15)

APPOINTMENT REMINDER LETTER - TUESDAY, JANUARY 26, 2016

Please be sure to bring this notice with you to your appointment

Tuesday
01/26/2016

Arrive At:
9:00 AM

Appointment Time:
9:00 AM

Campus:	UMMC	**With:**	Justin Kwan, MD
Building:	Frenkil	**For:**	Initial Visit
Address:	16 S. Eutaw St Baltimore, MD, 21201	**Phone:**	410-328-4323
		Best Parking:	Redwood Garage
Department:	NEUROLOGY CARE CENTER		
Floor/Suite:	300		

To better serve you, your appointment starts with our medical team of schedulers, nurses, medical assistants, research assistants, residents, and/or fellows. They collaborate with your doctor to gather important clinical and administrative information from you. As we provide comprehensive care to complex cases, you may experience some wait time during your visit.

Important Information Regarding your Medical Bills

Please note that the Neurology Care Center is considered a hospital outpatient setting.

- Your insurance company will receive multiple bills outlined on the right.
- At time of service come prepared to pay your copayment.
- Questions regarding your coverage, benefits & payment obligations? Please contact your insurance carrier.

1. Outpatient Hospital (Facility Fee) - This bill comes from the University of Maryland Medical Center. It covers supplies and cost of hospital staff that assist you with your visit. This may include nurses, lab work, and other testing.
2. Physician (Professional Fee) - This bill is for services provided by your physician from their private billing office.

UNIVERSITY of MARYLAND MEDICAL CENTER
Neurology
16 S Eutaw St, Ste 300
Baltimore, MD 21201

We value you as a patient. If you are unable to keep your scheduled appointment, please call **410-328-4323**.

Justin Kwan, MD
Physician

UMMC and UM Midtown Honored for Quality and Safety:

Both campuses of the University of Maryland Medical Center received prestigious awards in November for patient safety and quality-of-care measurements that not only met the standards for excellence, but exceeded them.

For more information:

http://umm.edu/news-and-events/awards-and-honors#ixzz3Jq7VNpdO

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Testimony of Dr. Joseph A. Gribbin
before the
House Health and Government Operations Committee
on
The Facility Right to Know Act (HB 849)
February 28, 2019

Thank you Chairman Pendergrass and the members of this committee for holding this hearing that is so important and central to the basic rights of patients. Thank you too for allowing me to testify as to my own experience of how things can go bad when a patient is not provided in advance with adequate pricing information.

My surprising and unfortunate experience centers on the University of Maryland Hospital's practice of charging a substantial hospital facility fee for patients who have routine doctor office visits two to three blocks away from the hospital in an entirely separate office building. Moreover, in my case, the assignment of these fees was done without appropriate prior notice to the patient. Finally, the amount of the fee, again - at least in my case, was more than eight times the amount of the charge for the office visit itself!

I had been seeing Dr. Raymond Flores, a University of Maryland rheumatologist to treat some swelling I had been having with my fingers. I had appointments with Dr. Flores on numerous occasions over the last decade including when I met with him at Kernan Hospital and at the U of MD facilities in Timonium and Columbia. The charges for all past visits never included any charge beyond that for the office visit and related services. My co-pay for the visits was a standard $20.

Due to scheduling issues, I made a routine follow-up appointment with Dr. Flores for an office visit on April 13, 2017 in the office building at 16 South Eutaw Street in Baltimore. The street map that I provided as an attachment to my testimony shows clearly the two to three block distance of the office building from the University of Maryland hospital. This old office building did not display any overt signage that suggested to me I was entering the hospital.

By the spring of 2017 I had reached a point in my care where Dr. Flores would simply want to look at my hands and monitor the dosage of prednisone that he had been prescribing. Thus, my visit in April of 2017 consisted of only a brief 15 minute discussion with Dr. Flores and his Physician's Assistant; no other testing or monitoring was performed. However, the billing process and the fees that were assessed following this office visit were very different from any of my past experiences.

My health insurance company (United Health Care GEHA) received Dr. Flores' claim for the April 13 office visit on May 10, 2017 for the amount of $205; my co-pay was $20. This claim fit totally within my expectations. Two days later on May 12, UHC GEHA received a second separate claim connected to the same office visit. The amount billed by the hospital was an additional $1,684.80 and my co-payment was an additional $166.80. These amounts are more than eight times the original assessments made for the office visit itself. The procedure code listed without explanation on this second bill's "Explanation of Benefits" was "HMRO". I was later informed by the University of Maryland's Medical System billing office that this indicated a hospital facility fee.

The University of Maryland Medical System touted in their patient "Bill of Rights" in 2017 that the patient had the right to understand the charges for the services rendered yet no one notified me of such facility fees either when I scheduled or came to my appointment. The only notification of the facility fee I received was the explanation of benefits after the fact from my insurance company. Even then it was left to me to interpret the "Procedure code": HMRO. Even the University of Maryland's billing office could not explain to me how the outrageous facility fee in my case was calculated. One billing office employee mused that it must have had something to do with the total amount of time I spent in the office building counting the time spent in the waiting room and the more than half-hour I spent in an empty exam room waiting for my 15 minutes with Dr. Flores and his P.A. However the dollar figure was arrived at, it did not reflect proportionality in any reasonable degree to the actual services rendered. The charge assessed for the actual office visit was $205 with my co-pay of $20 for my 15 minute visit. The facility fee assessed was an additional $1,684.80 with my co-payment of $166.80.

Dr. Flores and many of his colleagues keep appointment hours at suburban locations. If I had been aware of the facility fee policy in advance, I would certainly have chosen to work through any scheduling issues to see him at these alternate venues. In fact, I made a point to do just that following this unsettling experience. The absence of clear and proper notification to patients at the time appointments are scheduled that such facility fees may be assessed and how high they could be violates any reasonable standard of transparency and fairness.

If I may, I would like to take a moment to make a more general observation related to my experience. The vast majority of my federal career was spent as the Associate Commissioner of the Social Security Administration wherein I had lead responsibility nationally to assess the accuracy and quality of service the Agency and it 65,000 employees provided to the American people. In addition to assessing the accuracy of the Agency's work, we were constantly attentive to the views of beneficiaries and taxpayers as to whether our employees were helpful, professional and entirely transparent as to what Americans can expect from Social Security. Consistently and over decades the two items that proved most important to the American people have been and still are the Agency's integrity and transparency. Transparency was consistently interpreted as Americans feeling like we provided in a clear and timely manner everything they needed to know about their situation. Now in retirement, I am envious of this committee's ability

to advance in a concrete fashion integrity and transparency for many patients and for all of us state-wide who pay taxes and insurance premiums. The bill you have before you provides reasonable patient protection and ensures that all Marylanders would be treated as you would want to be treated yourselves.

Thank you again for the opportunity to convey my own experience and views on the proposed legislation.

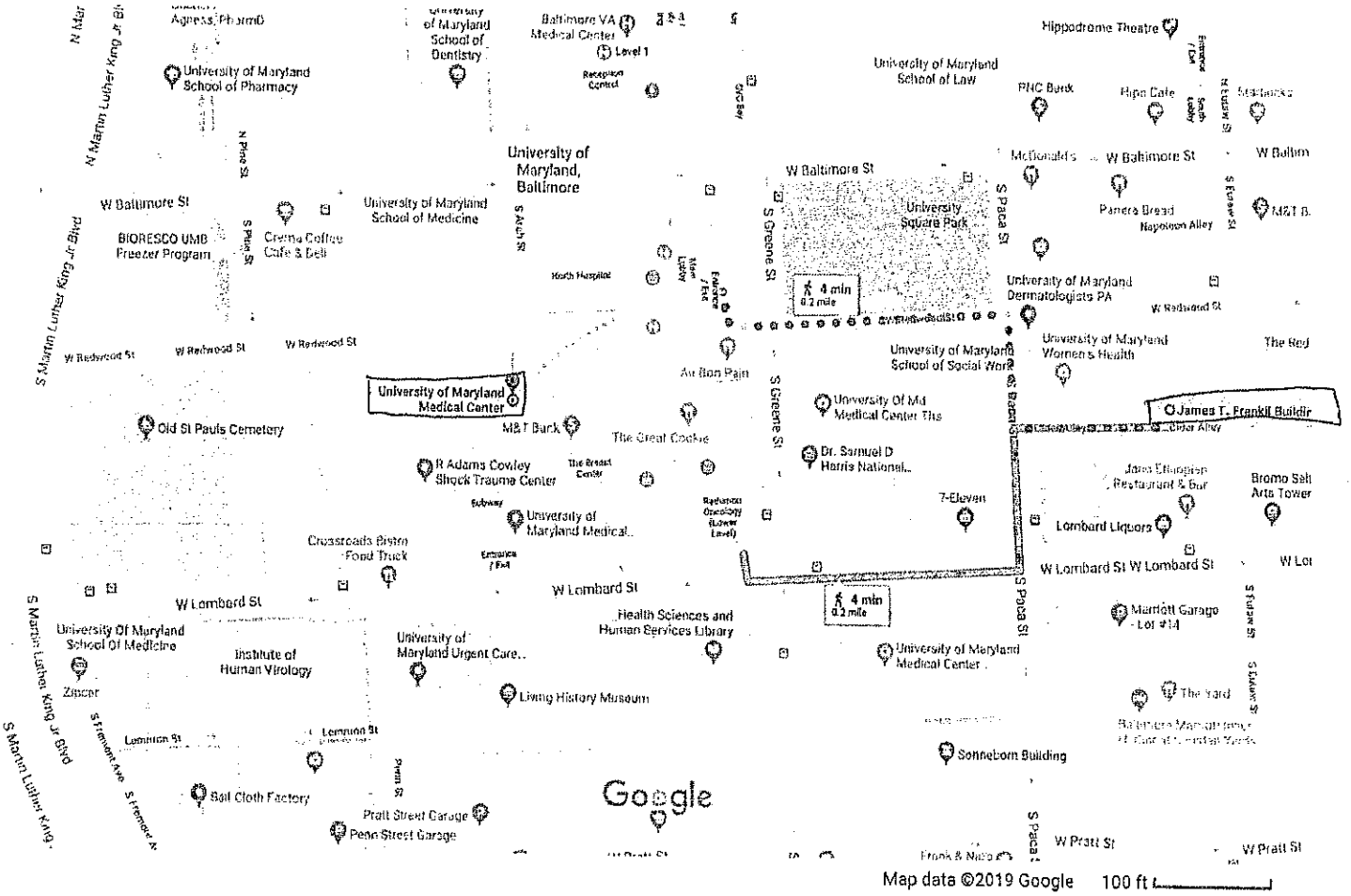
Dr. Joseph A. Gribbin

Attachment

Google Maps

James T. Frenkil Building to University of Maryland Medical Center

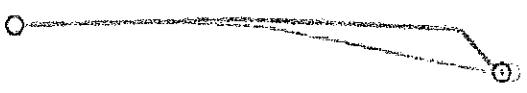
Walk 0.2 mile, 4 min



via Cider Alley and W Redwood St — 4 min, 0.2 mile

via Cider Alley and W Lombard St — 4 min, 0.2 mile

↑ 13 ft · ↓ 72 ft



From: Alissa Schaub-Rimel [mailto:readheaded@hotmail.com]
Sent: Wednesday, February 20, 2019 5:17 PM
To: justin.ready@senate.state.md.us; susan.krebs@house.state.md.us; haven.shoemaker@house.state.md.us; april.rose@house.state.md.us
Cc: HEAU <HEAU@oag.state.md.us>
Subject: Please Support SB0803, Health Facilities - Hospitals - Disclosure of Outpatient Facility Fees (Facility Fee Right-to-Know Act)

Dear Representatives,

I am writing to urge your support for SB0803, Disclosure of Outpatient Facility Fees (Facility Fee Right-to-Know Act).

Recently, I had what I thought was an appointment at a doctor's office on a Maryland hospital campus. Unfortunately, despite looking like a doctor's office, the appointment was actually in what is considered part of the hospital. Because I wasn't aware that I was seeing the doctor in the hospital, I was responsible for a $200 facility fee, in addition to my $50 specialist co-pay. Had I known I would have been charged a facility fee, I could have chosen to see the same doctor and received the same services at an alternate location and been responsible for only the $50 specialist co-pay.

It should be completely obvious and transparent when a patient is seeing a provider at a location that necessitates a facility fee. Fortunately for me, the $200 was an expensive, but affordable, lesson. But, as a well person with an advanced degree in health administration who still had no idea I was seeing a doctor in a hospital, I have to wonder how difficult it may be for someone who's sick and/or less educated and/or facing other obstacles to realize that they may be facing substantially higher costs for what seems like an ordinary doctor's appointment.

It should be absolutely clear to everyone before a medical visit if a facility fee will incurred. For that reason, I ask again for your support of SB0803.

Thank you,

Alissa Schaub-Rimel

From: Stephen [mailto:82hebert@live.com]
Sent: Saturday, February 16, 2019 9:16 PM
To: O'Connor, Patricia <poconnor@oag.state.md.us>
Subject: Facilities fee testimony

To whom it may concern,

My name is Stephen Paul Hebert Jr. I am a 36 year old male who resides in Baltimore city. I hereby grant permission to the Health Education and Advocacy Unit of the Attorney General's office to use my name and testimony in their pursuit for change. On Monday, May 8th, 2017 at 2:30 p.m., I had an appointment with my general practitioner Dr. Amy Burrell at Chase Brexton Health Services (Mount Vernon location). During this appointment, I requested two referrals. One was for a hematologist and the other was for a cardiologist. A month prior to this appointment, my mother had informed me that as I was nearing my 35th birthday, I should be tested to rule out a potential, genetic, blood-borne illness and a potential, genetic, heart valve defect. Considering the seriousness of these issues, I wasted no time in my quest to seek answers. Anyway, as my doctor was retrieving my referrals, she went through the trouble of finding specialists that were both close to my home and that accepted my insurance (were within my network). So, all I had to do was to call the offices of the specialists and schedule appointments. First, I started with the hematologist. I called the office of Dr. Lois Kamugisha and scheduled an appointment for July 10th, 2017 at 1p.m.. Before making the appointment, I clearly asked the receptionist about the cost of my visit. At that time, I was informed that based on my insurance, I was only responsible for paying a copay of $50. Besides the cost of the visit, I was also instructed to bring in a completed new patient packet that was to be mailed to me. The only other information that was relayed to me was the address and suite/office number (suite 109). I was never informed that this was a hospital or that I could be responsible for paying any facilities fees. After creating this appointment, I called the office of the cardiologist. Turn out, the office of Dr. John Marra was at the same address but, in suite 206 (one floor above Dr. Kamugisha's office). As I was scheduling an appointment for July 24, 2017 at 1p.m., I again, asked the receptionist about the cost of the visit. She also informed me that based on my insurance that I was responsible for paying a copay of $50. Once more, I was told to bring in a completed, new patient packet. This all seemed very simple and procedural for doctor's offices. However, just to be clear, with both of these appointments, I was never informed that they were located in a hospital and that I could potentially incur any facilities fees.

At about 12:30 pm on Monday, July 10, 2017, I arrived at 5601 Loch Raven Blvd. I walked into the building and found suite 109. Upon entering the office of Oncology and Hematology, I immediately noticed that it was disorganized and dilapidated. As I checked in with the receptionist, she informed me that this was a temporary office. The waiting area was so cramped that it was difficult to accommodate handicap patients entering the office (tables and desks had to be moved). Anyway, at the time that I checked in for my appointment, I paid my $50 copay. Once I was seen by Dr. Kamugisha, she quickly confirmed that I could in no way be a recipient of this potential, genetic blood-borne disorder. She also stated that no testing or further visits would be required. This came as a relief. However, the visit was less than 5

Outpatient Facility Fees

As in FY 2016 and FY 2017, the HEAU continued to receive complaints about hospitals charging surprising and excessive fees in connection with physician office visits in outpatient facilities. Maryland's Health Services Cost Review Commission's ("HSCRC") current regulations do not require hospitals or providers to tell patients, when they make their appointments, that they will be billed by both the provider and the hospital for the visit. The HSCRC regulations also do not require that patients be informed about the amount of the hospital's fee, or that patients be provided a high-low estimate, at the time an appointment is made or when presenting at the registration desk for the appointment.[1] Patients consistently complain that they should have been given this information to make an informed decision about where to seek care. Some patients advise that would not have seen a doctor at the outpatient facility if the amount of the hospital's fee had been disclosed at the time of making an appointment. If told the fee amounts, they would have chosen to see the provider in a regular office, or if that is not an option, would have seen another provider in a setting where no facility fee is charged.

From a consumer viewpoint, current HSCRC regulations are inadequate because they merely require that a facility's location and signage alert "the public that a given building or service is either at the hospital or not at the hospital" and that "billing reflect clearly that the service is rate regulated or not rate regulated." Interestingly, the HSCRC has approved some floors of an outpatient facility as regulated space, and not others, making location and signage a nearly meaningless indicator for consumers. In addition, often the hospital outpatient facility is a physician's office that had been acquired by the hospital, but continues to appear to the public as a physician's office.

[1] Under Medicare regulations, in contrast, when an outpatient facility is not located on the main hospital's campus, and coinsurance will be charged by the physician and the hospital, the patient must be given written notice by the hospital before the delivery of services that states (1) the amount of the patient's potential financial liability or (2) if the amount is unknown, an explanation that the patient will incur coinsurance liability to the hospital which would not be incurred at a non-hospital facility, an estimate based on typical or average charges, and a statement that actual liability will depend on actual services furnished by the hospital. 42 CFR 413.65(g)(7)(i)(A)-(B).

Complaints reveal there is a big gap between what hospitals and regulators say consumers should understand about the fees based on signs and form language, and what consumers say they in fact understood - until they receive a surprise bill from the hospital.

As reported in FY 2017, the HEAU asked for documents and explanations from hospitals to establish when and how they provide patients notice of outpatient facility fees. The HEAU received responses from five Maryland hospital systems in connection with 15 complaints. The responses revealed that no hospital informs patients of the amount of the fee, or the high-low range of fees, at the time an appointment is made or at the time patients present to registration for their appointments.[2] The following is a summary of the hospitals' responsive information:

Hospital 1: No oral notice is given at time of making an appointment. "Our representatives do not verbally tell the patients when they schedule an appointment that there will be a facility fee charged." Pre-appointment documents are mailed to patients, including a billing notice that states "you will receive a physician services bill from the doctor and an outpatient clinic bill from [hospital name]. Together, the two bills will represent charges incurred during your visit to the center." The same notice is given to the patient for signature at the time of service. No information is given about the amount of the facility fee until the patient is billed. Six of the complaints about this hospital involve doctor/hospital fees of $454/$1,729, $425/$1,141, $475/$627, $297/$577, $345/$553 and $425/$296. The patients contend they did not understand they would be charged facility fees, or that they would be so high.

Hospital 2: One hospital outpatient campus never responded to the HEAU's requests. Another campus stated that the patient would not have been advised of the regulated facility fee during the appointment scheduling phone call. According to the hospital, an electronic "My Chart" appointment reminder is sent, including appointment instructions that state, in part: "1. Please arrive 20 minutes early to allow time for registration. 2. Please note this is a Hospital based clinic. You may have two co-pays or co-insurance amounts as well as receive a bill for both a professional fee and a facility fee." Two of the complaints about this hospital involve doctor/hospital fees of $91/$260 and $355/$143.

Hospital 3: According to the hospital, patients are notified by the name of the hospital on signs. The hospital asserted that it provides oral notice that facility fees may be charged at the time an appointment is made, contending that there is a script for schedulers to inform patients they are coming to a hospital-based center, and to advise patients to check with their insurers about what the patient will pay out of pocket. When time allows, pre-appointment papers are mailed along with a three-page document entitled "Understanding Your Medical Bill." The same document is given to patients in paperwork to be signed at the time of service. On page one, the document states: "Patients treated in an outpatient setting (for example, a clinic, emergency room, or surgery) or admitted to the hospital may

[2] It appears this fee information is available because the HEAU has received complaints that some hospitals, labs, radiology practices and other providers are requiring pre-payment of patient co-insurance and outstanding deductible amounts for professional services and hospital services, and that overpayments are not always reimbursed.

receive multiple bills. You may have to pay a co-pay, deductible and/or co-insurance for the physician and hospital services. ... The hospital outpatient bill includes charges for the use of the hospital facility and any tests or procedures you undergo." Similar information is included on page three. Five of the complaints about this hospital involve doctor/hospital fees of $205/$1684, $119/$1,489, unknown/$1,342, $50/$327 and 3 charges for one patient ($225/$1,342, $155/$170 and $340/$138). The patients contend they did not understand they would be charged facility fees, or that they would be so high.

Hospital 4: No oral notice or specific written notice is provided about outpatient facility fees. Patients are advised in writing to check with their carrier about co-pays and deductibles. One of the complaints involved a $1,777 hospital fee. The patient said he did not know he would be charged a facility fee.

Hospital 5: The hospital reports its outpatient facility locations and signage make patients aware they will be billed a facility fee. The hospital says its regular practice is to orally notify patients at the time they register that "they will receive facility and physician fees for their treatment." This information "is contained in the Consent for Medical Treatment that is typically signed by patients at their first visit." One of the complaints involved doctor/hospital fees of $165/$165. The patient said he asked about costs when making the appointment and was advised only about a $50 co-pay.

The HEAU has concluded that patients need explicit cost information when making their appointments to avoid surprise bills for outpatient facility fees. The signage and vague language used by hospitals is ineffective; consumers continually fail to appreciate their financial risk because they are not told the exact fee or even a high-low range of fees at a time when they could choose another provider or treatment location. The following statements are representative of consumers' distress about current practices:

> "I object to the bill since (1) the fee was NOT disclosed to me & had I been given the choice, & made aware, I would have gone elsewhere with no fee (2) the fee seems EXCESSIVE & UNUSUALLY HIGH above what is usual & customary charge for a visit (3) It presents a financial hardship to me that could have been avoided had it been disclosed (4) I have repeatedly asked the [hospital] to either forgive or reduce the remaining balance due to something more reasonable (more like $200-350 which is still charging me twice for the same appointment!)....I think if a fee is so large, the patient should be warned there could be [a] fee, and how much the fee will be so they can make an informed decision if they want to pursue the treatment. Most people would only expect a doctor's office visit fee, not a fee to pay the hospital to use their space!"

> "..., my complaint centers on the [hospital's] practice of charging a substantial hospital user fee for patients who have routine doctor office visits two blocks away from the hospital in an entirely separate building - an office building. Moreover and in my case, the assignment of these fees were done without any prior notice to me, the patient. Finally, the amount of the fee, again - at least in my case, was more than eight times the amount of the charge for the office visit itself!"

"...[my doctor] keeps appointment hours at suburban locations; if I had been aware of the usage fee policy in advance, I could have chosen (as I have in the past) to see him at these alternate venues. The absence of proper notification of patients both at the time of scheduling and at the appointment itself also smacks of abuse of the patient/consumer."

The HEAU believes that hospitals and providers are failing to provide consumers with material information and that this failure could violate the Maryland Consumer Protection Act. The HEAU's review is ongoing and could result in Consumer Protection Division enforcement. However, this problem may also warrant a regulatory or legislative response.

http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/annualreports.aspx

COMPLAINT INFORMATION

Please include a copy of the signed Authorization for the Release of Medical Information and copies of all bills, receipts, explanation of insurance benefits (EOBs), insurance card(s) and any other papers related to your complaint. Having copies of the relevant documents will allow us to assist you more quickly.

Have you received the service, care or product? Yes

If so, when was the service, care or product received? 3.7.2016

What type of product or service is involved in the dispute?

I was a new patient of Dr Wendy Lynet BENNETT on 2.1.2016. I contacted her by phone to get a reference for an otolaryngologist. She insisted I come to her office. I came she provided the reference & I left. I paid the balance

Please tell us about your problem.

3.7.16
on the $91.00 charge for the visit (which I felt was unnecessary in the first place), Because she refused to provide me with the reference via phone, email or HOPKINS "My Chart", I had to loose time from work that was not compensated & incurred expenses for gas & parking - ALL UNNECESSARY! Then I recieved an additional bill for the balance on the $265.86 facility charge. Cigna paid $83.23 & I was charged $177.31 after a charitable (and unsolicited) discount of $5.32 from Cigna, I think, little matter! The amount of my dispute is $177.31.
I am new to Baltimore. My husband & I married in 2014. I might be 'old school' but calling my PCP to get a referral for a specialist is the only way I know to get my problem resolved. I respected Hopkins (note past tense) but clearly its "all about the Benjamins" and not too much about controlling costs $355.86 just to get a name. Sad.

COMPLAINT INFORMATION

Please include a copy of the signed Authorization for the Release of Medical Information and copies of all bills, receipts, explanation of insurance benefits (EOBs), insurance card(s) and any other papers related to your complaint. Having copies of the relevant documents will allow us to assist you more quickly.

Have you received the service, care or product? YES

If so, when was the service, care or product received? 1/26/2016

What type of product or service is involved in the dispute?

ON 1/26/16 I had an office visit to Dr. Justin Kwan in the University of Maryland's Baltimore office : The Neurology Department at 16 S. Eutaw St. Ste. 300, Baltimore MD 21201

Please tell us about your problem. I saw Dr. Justin Kwan on 1/26/16 for a Neurology Consultation. At no time during setting up the appointment, in the paperwork sent to me, or upon arrival was I made aware of the extra charge for "Use of Facility Fee" charged by the university. I did not have a Facility Fee from the referring Dr. (Paul McAfee) who is also part of the University of MD (Towson office), only a $138.49 bill. Dr Kwan's bill of $119.52 was paid by me on 3/17/16 by phone. I was shocked to later receive a bill of $1,465.82. Upon calling Dr Kwan's office to question the bill, I was told that the bill was not from them, but from the University of MD for use of office space. I asked why I was charged this since I paid Dr Kwan and no special tests were done during the 90 minute appointment. Other doctors with similar office visits have not charged a separate fee for using office space! I object to the bill since 1) The fee was NOT disclosed to me & had I been given the choice, & made aware, I would have gone elsewhere with no fee (2) The fee seems EXCESSIVE & UNUSUALLY HIGH above what is usual & customary charge for a visit (3) It presents a financial hardship to me that could have been avoided had it been disclosed 4) I have repeatedly asked the University to either forgive or reduce the remaining balance due - to something more reasonable (more like $200-$350 (which is still charging me twice for the same appointment!) It seems an unfair & deceptive trade practice to double charge a patient and to not disclose the charge. These practices will discourage patients from seeking medical care in the State of Maryland!

Also, I think once I may have been charged a fee from a hospital when I saw a doctor, but from what I remember it was a nominal fee comparable to what the doctor himself charged. I think if a fee is so large, the patient should be warned there could be fee, and how much the fee will be so they can make an informed decision if they want to pursue the treatment. Most people would only expect a doctor's office visit fee, not a fee to pay the hospital to use their space!

COMPLAINT INFORMATION

Please include a copy of the signed Authorization for the Release of Medical Information and copies of all bills, receipts, explanation of insurance benefits (EOBs), insurance card(s) and any other papers related to your complaint. Having copies of the relevant documents will allow us to assist you more quickly.

Have you received the service, care or product? yes

If so, when was the service, care or product received? 05/27/2017

What type of product or service is involved in the dispute?

Sinai Hospital charging facility fees (overhead costs associated with visit, e.g. heating, lights, power, janitor, supplies, secretary etc.) for the use of their office building on top of the doctor's bill.

Please tell us about your problem.

I went to Dr. Braeme Glaun on 05/27/2017 for an Electromyography (EMG) at Sinai Hospital's Neurology Clinic. I received a bill from Dr. Gaun for $1,059.00 with a plan discount of $609.65. My portion was $454.35 which was paid out of my Health Savings Plan. I then received a bill from Sinai for $1,746.74 with a plan discount of $17.47. My Health Savings Plan paid $479.03 and $261.70 out of the remaining money I had in my Health Savings Plan. Leaving a balance of $988.54 due Sinai.

My complaint is first receiving a bill from Sinai for utilities, maintenance and salaries of employees at their office complex. When i go to my family doctor I get one bill from the Practice; not one from the doctor and one from the facility. I had no idea i was going to get that bill.

When I called to make the appointment about a month and half prior to getting the appointment, I had to submit all of my insurance information. If the hospital knows it will charge these fees, it should tell me then the costs and send me a copy of all fees they are going to charge. I have no recollection of ever being told about these fees. I have no recollection of ever being told about these fees. If I did sign anything, it was when i was there and they gave me ten other papers to sign (which I do not remember signing).

I would not have taken this appointment had they informed me the costs. I had an appointment with another doctor but that was two months out and i was in a lot of pain.

The second issue is, I was in and out of my doctor appointment in a total time of less than an hour (45 min). How can Sinai charge me $1,746.74 for that amount of time? I feel that what I paid the doctor and his staff was more than reasonable, and those hospital fees should come out of that money as rent from the doctor.

I filed a complaint with the BBB, and Sinai (Amanda Rabinwitz) responded that the Health Services Cost Review Commission, a state agency, sets and allows these fees. I cannot believe when the Health Services Cost Review Commission got together to discus these fees, this is what they thought they were agreeing to.

I then got in touch with, Dennis Phelps, at the State of Maryland Department of Health, and the indicated that these fees were high but allowable.

How has the business responded to you? With whom did you speak?

Amanda Rabinwitz, from Sinai, responded that the Health Services Cost Review Commission, a state agency, allows and sets these fees and I have to pay them.

What would you like the insurance carrier, provider or business to do to resolve your complaint?

I paid Dr. Glaun his bill of $454.35 and Sinai the $758.73 out of my money already. I do not think for the 45 minutes I spent at the Sinai facility, I should have to pay the remaining $988.54.

I also would like the Attorney General Office to look into this practice of hospitals charging patients these facility fees. If they do allow the hospital to charge them; the hospital should be required prior to the appointment to send a copy of the total charges they are charing the patient, and have them sign it prior to walking into the facility.

I have no idea how I was "Appropriately notified" by Sinai about these fees.

Is there any additional information you would like to add?

I told my hand surgeon about this, and he said he was taken in by it too. He also submitted a complaint. To me, this may be legal somehow, but very Unethical.

Thank you for your submission to the Consumer Protection Division.

Your reference number is: 291619

The following is the information you have submitted on January 10, 2018 at 02:18 PM:

First Name	
Last Name	
Address	
City	Salisbury
State	Maryland
Zip Code	21804
Best Telephone Number to use during the day	
E-Mail Address	
Name of Doctor or Business	DR JANINE GOOD and DR WALTER ROYAL
Business Address	16 S Eutaw St
Business City	Baltimore
Business State	Maryland
Business Zip Code	21201
Business Telephone Number	(410) 328-4323

Dear Attorney General Frosh, I am writing you to form a dispute against neurologists Dr Janine Good and Dr Walter Royal at the University of Maryland. I was referred to Dr Good by my primary for treatment of chronic headaches. My first visit was with Dr Good on 10-19-17. I presented her with my symptoms and she said she would like to consult with Dr Royal before beginning any treatment to make sure my MS diagnosis from my local neurologist is correct. She was not convinced my diagnosis was true and thought there may be something else going on. I left her my brain MRI to review with Dr Royal. I then received a call from the office saying Dr Royal would like to see me as an office visit to speak with me himself and perform his own neuro exam to help form a diagnosis. My appointment time was 12:45pm on 11-16-17 with Dr Royal. My husband and I live a few hours away and arrived almost an hour early since traffic was good that morning. We noticed Dr Royal walk into the lobby at ~1:05pm, 20 minutes after my appointment start time. It was yet another 15-20 minutes before we were called

Description of the problem or dispute	back into the room by his new graduate doctor. This grad doctor asked about my symptoms and performed a neuro exam. I was under the impression Dr Royal would want to see the neuro exam himself, as this was to help him form a diagnosis. The grad doctor left the room to review the information with Dr Royal and return with him. We waited in the exam room for almost an hour before they walked in. Dr Royal asked me more questions regarding my symptoms and concluded he felt it was MS and recommended a repeat spinal tap, since my first one didn't even test for the MS protein bands needed for a diagnosis. He then left the room, leaving the grad doctor to finish the appointment. My next visit was 11-28-17 with Dr Good. The office never called to set up my spinal tap, so Dr Good could not begin the steroid treatment she wanted to since this would interfere with the tap results. She started a different medication instead and said she would look into the tap appointment. The office still has never called to schedule that tap. The bills began to come in and I was charged 'clinic fees' for each visit on top of my $50 copay per visit ($150 total). Making the initial visit I was told on the phone my insurance is accepted and I am responsible for my copays. No one disclosed any possibility of 'clinic fees' to me. When I called the billing department to get an explanation of what 'clinic fees' are and how are they charged; I was informed the Dr's make their own fees, they are charged per hour and the fee is for walking in and 'using' their facility. I was charged $188.48, $1,342.95 and $170.10 consecutively for 'clinic fees' in addition to my copays. I was charged by Dr Royal over a thousand dollars to walk in the door. If I had known this before my initial visit I would have never seen either Dr because I know I cannot afford this kind of out of pocket cost. If someone had mentioned this to me as a possibility over the phone, this whole situation could have been avoided because I would not have gone. I was made to wait for hours by Dr Royal and then charged for all of them. This is not fair and taking advantage of patients. I would have never even seen Dr Royal for an office visit if Dr Good hadn't suggested it. I followed the recommendations of a Dr and got ripped off for it. Time waiting on the Dr should not be billable. The billable time should be when the Dr is actually in the room, face to face with the patient. I do not feel that I should be responsible for the total of $1,701.53 in 'clinic fees' since no one informed me of any such fees in the first place. I have no problem paying the $150 in copays, that amount was obviously expected, but that is an insane amount of money to pay for 'walking in the door'. It's a shame that Dr's take advantage of and rip off the patients they are supposedly trying to take care of and help. If they want to help their patients, they would try to conserve their funds so they are able to return for further treatment and receive the help they are expecting. This makes me never want to go back to another Dr again and receive treatment for fear of not knowing what outrageous charge I will be forced to pay. I am a middle class, paycheck to paycheck person. I need to know any out of pocket costs up front. When I ask an office and I am told 'just your copay'... I'm not expecting a $1,701.53 bill. I need to take care of my family with this money. I sincerely hope you can put yourself in my shoes and understand where I am coming from. Thank you very much for your time, it is greatly appreciated!
How did you hear about our office?	Attorney General's Website
What would you like the business to do?	I would like the business to 1) admit they were wrong to not disclose any extra 'clinic fees' to me, the patient, that I would be responsible for other than my copays and 2) Waive the 'clinic fees'.
Patient's	

CareFirst BlueChoice.

BlueChoice Silver 3500 VisionPlus

Coverage Period: 01/01/2018 - 12/31/2018
Coverage for: Individual | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit http://content.carefirst.com/sbc/contracts/AHNMCN6JRXXMCN6B.pdf.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $3,500 individual/ $7,000 family	Generally, you must pay all the costs from provider up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Generic drugs, Outpatient surgery, Urgent care, Mental Health office visit, Home health, Rehabilitation services, Hospice.	This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Pediatric Dental: In-Network: $25 individual; Out-of-Network: $50 individual. Prescription Drug: $250 individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical and Prescription Drug combined: In-Network: $7,350 individual/ $14,700 family	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further

What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call **1-855-258-6518** for a list of provider network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: $30 copay per visit Hospital Facility: Deductible, then $100 copay per visit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, prior authorization is required, and the additional Facility charge may apply
	Specialist visit	Provider: $40 copay per visit Hospital Facility: Deductible, then $100 copay per visit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, prior authorization is required, and the additional Facility charge may apply
	Retail Health Clinic	$30 copay per visit	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preventive care/screening/ immunization	No Charge	Not Covered	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	LabTest: Non-Hospital: $25 copay per visit Hospital: Deductible, then $90 copay per visit XRay: Non-Hospital: $55 copay per visit Hospital: Deductible, then $130 copay per visit	LabTest: Non-Hospital: Not Covered Hospital: Not Covered XRay: Non-Hospital: Not Covered Hospital: Not Covered	In-Network Lab Test benefits apply only to tests performed at LabCorp; For services provided at a Hospital Facility, prior authorization is required
	Imaging (CT/PET scans, MRIs)	Non-Hospital: $250 copay per visit Hospital: Deductible, then $500 copay per visit	Non-Hospital: Not Covered Hospital: Not Covered	For services provided at a Hospital Facility, prior authorization is required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rx	Generic drugs	$10 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 30-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	Deductible, then $50 copay	Paid As In-Network	
	Non-preferred brand drugs	Deductible, then $70 copay	Paid As In-Network	
	Preferred Specialty drugs	Deductible, then $100 copay	Not Covered	
	Non-preferred Specialty drugs	Deductible, then $150 copay	Not Covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: $300 copay per visit Hospital: Deductible, then $450 copay per visit	Non-Hospital & Hospital: Not Covered	For services provided at a Hospital Facility, prior authorization is required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	Physician/surgeon fees	Non-Hospital: $40 copay per visit Hospital: Deductible, then $40 copay per visit	Non-Hospital & Hospital: Not Covered	For services provided at a Hospital Facility, prior authorization is required
If you need immediate medical attention	Emergency room care	Deductible, then $300 copay per visit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	Emergency medical transportation	Deductible, then $40 copay per visit	Paid As In-Network	Prior authorization is required for air ambulance services, except when Medically Necessary in an emergency
	Urgent care	$60 copay per visit	Paid As In-Network	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $500 copay per day	Not Covered	Prior authorization is required Member maximum payment: Participating Provider: $2,500 per admission
	Physician/surgeon fee	Deductible, then $40 copay per visit	Not Covered	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 copay per visit	Office Visit: Not Covered	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then $500 copay per day	Not Covered	Prior authorization is required; Additional professional charges may apply; Member maximum payment: Participating Provider: $2,500 per admission
	Office visits	No Charge	Not Covered	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery professional services	Deductible, then $40 copay per visit	Not Covered	None
	Childbirth/delivery facility services	Deductible, then $500 copay per day	Not Covered	Additional professional charges may apply; Member maximum payment: Participating Provider: $2,500 per admission
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization is required
	Rehabilitation services	Provider: $40 copay per visit Hospital Facility: Deductible, then $100 copay per visit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, prior authorization is required, and the additional Facility charge may apply; 30 visits/therapy type/condition/benefit period
	Habilitation services	Provider: $40 copay per visit Hospital Facility: Deductible, then $100 copay per visit	Provider & Hospital Facility: Not Covered	Prior authorization is required; If a service is rendered at a Hospital Facility, the additional Facility charge may apply; Benefits available for Member age 19 and older are limited to 30 visits/therapy type/condition/benefit period
	Skilled nursing care	Deductible, then $100 copay per admission	Not Covered	Prior authorization is required; 100 days/benefit period
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice services	Inpatient Care: No Charge Outpatient Care: No Charge	Inpatient Care: Not Covered Outpatient Care: Not Covered	Prior authorization is required
	Children's eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to Members up to age 19; Limited to 1 visit/benefit period

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's glasses	No Charge	Allowances available for glasses/lenses	Limited to Members up to age 19; Limited to 1 set of glasses/ lenses per benefit period
	Children's dental check-up	No Charge	20% of Allowed Benefit	Limited to Members up to age 19; 2 visits/benefit period

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Long-term care	• Routine foot care
• Coverage provided outside the United States. See www.carefirst.com	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion, except in limited circumstances	• Chiropractic care	• Routine eye care (Adult)
• Acupuncture	• Hearing aids	
• Bariatric surgery	• Infertility treatment	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maryland Insurance Administration, http://insurance.maryland.gov/Consumer, or call 1-800-492-6116. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Maryland Insurance Administration, http://insurance.maryland.gov/Consumer, or call 1-800-492-6116.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.